No. 89-210

Supreme Court, U.S.
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IN THE

SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1989

HARLEY AMOS AND GAIL AMOS,
Petitioners

v.

BLUE CROSS BLUE SHIELD OF ALABAMA,
JAN CULLIGAN,
Respondents

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

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QUESTION FOR REVIEW

Does the Federal Judiciary have the obligation to develop a federal common law under ERISA in order to protect the beneficiaries of medical insurance plans and to achieve the intent and purposes of ERISA by providing full compensation for wronged beneficiaries including, when appropriate, punitive damages in order to discourage future similar wrongs?

LIST OF ALL PARTIES

Pursuant to Rule 21.1(b), Rules of the Supreme Court, counsel for petitioners' certify that the complete list of all parties to the proceeding below and all parties and persons believed to be interested in the outcome of this Petition, includes:

Harley Amos

Gail Amos

Blue Cross Blue Shield of Alabama

Jan Cullighan

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ERISA's Fundamental Contradiction: The Exclusive Benefit Rule, 55 University of Chicago Law Review 1105 (1988)

REFERENCE TO DECISION TO BE REVIEWED

The case to be reviewed is Harley Amos and Gail Amos, Plaintiffs-Appellees vs. Blue Cross Blue Shield of Alabama and Jan Cullighan, Defendants-Appellants, 868 F.2d 430 (11th Cir. 1989), a copy of which is attached as Appendix A. This was an Appeal from a Decision entered by the United States District Judge William M. Acker, Jr., on March 22, 1988, cited as: Amos vs. Blue Cross Blue Shield of Alabama, 681 F. Supp. 1515 (N.D. Ala. 1988), a copy of which is attached as Appendix B.

STATEMENT OF JURISDICTION

This Court has authority for this review under 28 U.S.C. 2101. The Eleventh Circuit Court of Appeals entered its Decision in this cause on March 24, 1989, and thereafter, Harley Amos and Gail Amos,

by and through their attorneys of record, filed petitions for Re-Hearing and Suggestion of Re-Hearing in Banc which was denied by the Eleventh Circuit Court of Appeals on May 5, 1989.

STATEMENT OF THE CASE

This action arises out of a grossly wrongful and inexcusable denial of claim for insurance benefits under an employee insurance benefit plan as defined by ERISA. The action was initially filed in Circuit Court of Etowah County, Alabama, against Blue Cross Blue Shield of Alabama (Blue Cross) and Jan Cullighan, an employee of Blue Cross. The complaint asserted various state law claims against defendants for breach of contract, fraud in the inducement and bad faith. Because the insurance contract at issue was obtained through the plaintiffs' employer, the defendants removed the action from the State Court to the Federal Court, namely the Northern District of Alabama. With their Petition for Removal, the defendants filed a Motion to Dismiss or in the Alternative Motion for More

Definite Statement. Defendants asserted that all of plaintiffs' claims based upon State Law were preempted by ERISA and should be dismissed. In the alternative, defendants moved for an order directing plaintiffs to file an amended complaint setting forth any claims plaintiffs may have against the defendants under ERISA. Pursuant to the order granting the motion for more definite statement, plaintiffs filed an amended complaint on November 9, 1987. The amended complaint asserts claims both under ERISA and Alabama Common Law and seeks to recover compensatory and punitive damages.

On November 6, 1987, defendants filed a motion to strike all claims for damage, other than for the benefits themselves, so as to strip the plaintiffs of their admitted pre-ERISA right to full compen-

sation for the wrongs committed against them by the defendants Blue Cross-Blue Shield of Alabama, et al. In this motion, defendants asserted that under ERISA plaintiffs are not entitled to damages other than the benefits provided for by the Plan. In other words, no matter how egregious or wrong or willful and even fraudulent the denial, Plaintiffs' going to Court can only obtain from them, according to the defendants, are the right to have medical bills, interest and if the court, in its discretion, wishes to award attorney's fees, then, that would also be an allowable benefit, but nothing else to compensate the plaintiffs for all of the other injuries, damages and losses suffered by the plaintiffs as a result of the defendants fraud, bad faith or intentional breach of contract. The United States District Court denied the defendant's motion

by Order dated December 30, 1987. On January 20, 1988, defendants filed a petition for leave to appeal the District Court Trial Judge's Order. This petition was denied by the United States Court of Appeals for the Eleventh Circuit on February 24, 1988.

On March 9, 1988, defendants filed a motion for reconsideration regarding the Order dated December 30, 1987, in which defendants' motion to strike claims for full compensatory and punitive damages other than benefits was denied. The motion for reconsideration was denied by the Federal-District Court by Order of March 22, 1988. Defendants filed a petition for leave to appeal under 28 U.S.C., Section 1292(b) on April 1, 1988. This petition was granted by Order of the United States Court of Appeals for the Eleventh Circuit on May 11, 1988.

The appellant panel made up by Senior Circuit Judge Henderson, Judge Fay and Judge Anderson on March 24, 1989, entered an Order reversing the Federal District Trial Judge's Order and remanding the case to Federal District Court, among other things, said panel held the following:

> "Accordingly, we are compelled by controlling precedent to reverse the judgment of the district court. We acknowledge that by eliminating the possibility that insurance companies may be liable for punitive or extra-contractual damages, the courts are removing an historical disincentive to insurance company misbehavior. Consequently, our decision may produce unintended results. However, any change in the law's course will have to be charted by the Congress or the Supreme Court." (emphasis added).

Before the Eleventh Circuit opinion was rendered, Plaintiffs-Appellees supplemented their brief by sending to the panel whom had heard oral argument important legislative

history that clearly revealed Congress' intent that the Federal Judiciary develop substantive law under ERISA so as to enable wronged employees/beneficiaries to receive full compensatory damages including possible punitive damages, even if the remedies are not specifically enumerated in Section 502 of ERISA. Thereafter, within a very short period of time the panel's March 24, 1989, Order came out and therefore, the plaintiffs-appellees' attorney of record believes that the panel did not consider said Congressional intent/legislative history revelation in rendering its March 24, 1989 decision.

Thereafter, plaintiffs-appellees' attorney of record filed Petition for Re-Hearing and Suggestion of Re-Hearing in Banc, which was denied by the United States Court of Appeals for the Eleventh Circuit on May 5, 1989, a copy of which is attached hereto as Appendix C.

REASONS FOR GRANTING THE WRIT

Petitioners present a case of first impression that will affect each and every employee throughout America if he or she obtains his or her medical insurance or other insurances through his or her employer. Petitioners are aware of the fact that this Court has for consideration another petition for Certiorari in Rizzi v. Blue Cross of Southern California, Supreme Court No. 88-2055, which seeks to review the California Court of Appeals, 206 Cal. App. 3rd 350, a case which has some similarity to this case in that a Blue Cross Company denied benefits and successfully asserted ERISA preemption in the lower courts to protect it from any but minimum exposure. There are several reasons why this Honorable Court should issue a Petition for Writ of Certiorari to the Court of

Appeals for the Eleventh Circuit, review this case and thereafter enable the federal judiciary to develop common law under ERISA that will serve the purpose of ERISA by providing protection to the employees, who have obtained their insurance through their employers, from the wrongful misconduct of the insurance industry and/or the employers. Many Federal Appellate Courts and District Courts have entered decisions expressing frustration and clearly requesting this Honorable Court to chart a course of law that will enable the federal judiciary to create federal common law under ERISA not expressly provided by the statutory scheme as set forth in ERISA which as presently interpreted by many courts, including the Eleventh Circuit, enables the insurance industry and the employers to commit as much wrong as against the employees as they so

desire without fear of having to pay full compensatory damages and/or possibly suffer the sanction of punitive damages to thwart similar future wrongs. The United States Court of Appeals for the Eleventh Circuit in its decision of March 24, 1989, openly acknowledged that its decision was in fact protecting wrongdoers and punishing the innocent when the panel that entered the opinion concluded with the following lament:

> "We acknowledge that by eliminating the possibility that insurance companies may be liable for punitive or extra-contractual damages the courts are removing an historical disincentive to insurance company misbehavior. Consequently, our decision may produce unintended results. However, any change in the law's course will have to be charted by the Congress or the Supreme Court.

Amos, p. 1869.

In rendering the aforementioned decision, the panel's major mistake was in not detecting that the law's course has

already been charted by the Congress and/or by the Supreme Court and charted in a direction contrary to that of the panel.

The panel said it felt reluctantly bound by Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 107 S.Ct. 1549 (1987), which the panel erroneously interpreted as Blue Cross-Blue Shield of Alabama wanted it interpreted, namely, as holding that ERISA preempts all claims by the beneficiary of an ERISA-governed medical benefits plan, except that beneficiary's actual claim for bene-fits. Blue Cross argued, and the panel agreed as follows:

> "In the instant case, there can be no dispute that the common law causes of action asserted by the plaintiffs--bad faith refusal to pay, fraud and breach of contract -- "relate to" an employee benefit plan and therefore, fall within ERISA's express preemption clause." Amos, p. 1868 (emphasis added).

The panel correctly recognized that Mr. and Mrs. Amos are endeavoring to bring traditionally "common law" claims under the ERISA umbrella, but the panel concluded "that the effect of ERISA preemption is to wholly eliminate state law claims, leaving plaintiffs only the causes of action expressly provided for in the ERISA civil enforcement provisions." Amos p. 1868 (emphasis added).

We respectfully suggest that the panel fell short when it failed to mention or to realize the significance of Firestone Tire & Rubber Co. v. Bruch, _____U.S._____, 109 S.Ct. 948 (1989). Bruch, which was not decided until February 21, 1989, perhaps did not come to the panel's attention in time to be factored into its opinion. Nevertheless, Bruch constitutes that hoped for "change in the law's course ... charted by ... the

Supreme Court." Amos, p. 1869. The Supreme Court in Bruch, a month before Amos, had already accepted the panel's invitation to chart a different course, a course which would provide a disincentive to insurance company misbehavior and which would not produce unintended results. Not only does Bruch very clearly overrule the Eleventh Circuit's previous holdings that the turning down of ERISA claims by an insurance company evaluator is to be judged under the "arbitrary and capricious" standard, but Bruch very clearly rejects Blue Cross' current argument that no ERISA plaintiff can ever have a cause of action unless "expressly provided for in the ERISA civil enforcement provisions." Amos, p. 1868. Except for one relatively unimportant section of the Bruch opinion, the Supreme Court was unanimous. This Court there said:

"ERISA abounds with the language and terminology of trust law. See, e.g. 29 U.S.C. Sec. 1002(7) ("participant"), 1002(8) ("beneficiary"), 1002(21)(A) ("fiduciary"), 1102(a) ("trustee"), 1104 ("fiduciary duties"). ERISA's legislative history confirms that the Act's fiduciary responsibility provisions, 29 U.S.C. Sec. 1101-1104, "codif[y] and make [ ] applicable to [ERISA] fiduciaries certain principles developed in the evolution of the law of trusts." H.R. Rep. No. 93-533, p. 11 (1973), U. S. Code Cong. & Admin. News 1974, pp. 4639, 4649. Given this language and history, we have held that courts are to develop a "federal common law of rights and obligations under ERISA-regulated plans." Pilot Life Ins. Co. v. Dedeaux, 481 U.S. at 56, 107 S.Ct. at 1558.

See also, Franchise Tax Board v. Construction Laborers Vacation Trust, 463 U.S. 1, 24 N. 26, 103 S.Ct. 2841, 2854, N. 26, 77 L.Ed. 2d 420 L.Ed. 2d 420 (1983) (" 'a body of Federal substantive law will be developed by the courts to deal with issues involving rights and obligations under private welfare and pension plans" ') (quoting 129 Cong. Rec. 29942 (1974) (remarks of Senator Javits)."

109 S.Ct. 954 (emphasis added).

As the panel said on March 24, 1989, Mr. and Mrs. Amos' "complaint asserted various state law violations, including fraud and bad faith refusal to pay ..." Amos, p. 1866. It goes without saying that an action for fraud seeks a "common law" remedy. It is a cause found in every common law jurisdiction. It provides a remedy available against fiduciaries and trustees. No court, federal or state, has yet said ERISA immunizes a group medical benefits plan from claims based on the claims evaluators' own willful, fraudulent misconduct. If we are to take at face value what the panel and Blue Cross said on March 24th, Blue Cross can, with perfect impunity, deny a claim to save money or for a personal reason, which invidiously and maliciously discriminates against or abuses, a plan beneficiary. The Supreme Court, in Bruch,

clearly recognizes that Congress, in enacting ERISA, never intended for beneficiaries to be helpless or for the courts to be impotent when an ERISA fiduciary is deserving of more than a simple money judgment against him, or against the fund he administers, for the relatively small sum of money which he has wrongfully refused to pay. In most instances, a claims evaluator, as in the case of Blue Cross, has the conflict-of-interest recognized in Bruch. His loyalty is to Blue Cross, his employer, not to Mr. and Mrs. Amos. To give him the freedom, despite his self-interest, to deny a claim without exposing himself to any "extra-contractual" damages is to invite callousness and chicanery, something which Congress, according to the Supreme Court in Bruch, did not intend to invite.

Not only does Bruch point in a

different direction than the panel's opinion of March 24th, but there is a recent legislative history which is even more persuasive than the legislative history cited by the Supreme Court in Bruch for the proposition that Congress, in adopting ERISA, fully intended for the courts to fashion appropriate federal common law, as necessary to accomplish the larger purposes of ERISA. As recently as 1988, the Education and Labor Committee of the House of Representatives described that legislative intent as follows:

> "In recent years, the Committee has received numerous complaints and inquiries from Members of Congress and their consitutents about improper denials of medical claims, improper denials of continuation coverage, or unreasonable delays in processing claims by employers or insurers. Participants in ERISA-covered employee benefit plans that have been treated in this manner are concerned that the Supreme Court's interpretation of ERISA (particularly as articulated in Pilot Life Ins. Co. v. Dedeaux, 107 S.Ct.

1549 (1987)) as preempting state laws that authorize punitive or other extra-contractual damages in connection with claims for benefits effectively denies them of legal recourse. The Committee shares their concern. In Pilot Life, the Supreme Court held that state common law claims against an insurance company for breach of contract and bad faith arising out of an improper denial of disability benefit claims under an ERISA-covered plan were pre-empted. In addition, the Supreme Court declined to fashion a federal common law remedy for improper processing of benefit claims holding that ERISA's civil enforcement provisions under Section 502, were intended to be the exclusive remedies afforded to plan participants and beneficiaries. The Committee disagrees with this latter conclusion.

The Committee believes that the legislative history of ERISA and subsequent expansions of ERISA support the view that Congress intended for the courts to develop a federal common law with respect to employee benefit plans, including the development of appropriate remedies, even if they are not specifically enumerated in Section 502 of ERISA. Since the issue of preemption and civil remedies under ERISA is within the exclusive purview of the labor

> committees of Congress, the Committee has, over the years, considered the option of amending the statute to encompass specifically several additional remedies. In light of the legislative history on this issue, however, the Committe believes such action is unnecessary. The Committee reaffirms the authority of the Federal Courts to shape legal and equitable remedies to fit the facts and circumstances of the cases before them, even though those remedies may not be specifically mentioned in ERISA itself. In cases in which, for instance, facts and circumstances show that the processing of legitimate benefit claims has been unreasonably delayed or totally disregarded by an insurer, an employer, a plan administrator, or a plan, the Committee intends the Federal Courts to develop a federal common law of remedies, including (but certainly not limited to) the imposition of punitive damages on the person responsible for the failure to pay claims in a timely manner."

H.R. Rep. No. 801, 100th Cong., 2d Sess, p. 2, at 63 (1988) (emphasis supplied).

It would seem, then, that not only has the Supreme Court accepted in advance the

Eleventh Circuit's invitation, but Congress accepted that invitation before it was issued.

There is another good reason for the Supreme Court to elaborate on what is meant by "preemption" before the insurance industry and the employers succeed in building an impenetrable fence around themselves, protecting themselves with respect to any and all wrongdoing they may desire to commit.

Although for Mr. and Mrs. Amos' Seventh Amendment right to a Jury Trial was denied by the District Court and they have not appealed from that ruling, the Seventh Amendment is implicated because Blue Cross' argument, if successful, simultaneously squeezes out Mr. and Mrs. Amos' right to a jury trial and their right to seek extra-contractual damages. Congress could not

have intended such over-kill and trampling on the Seventh Amendment, when the avowed purpose of ERISA was to protect beneficiaries and not fiduciaries.

In addition to a number of Jurist there are legal scholars who seriously question the form of total so-called "preemption" being enunciated by some Courts contrary to the ERISA intent.

One such expression is found in Fischel and Langbien, ERISA'S Fundamental Contradiction: The Exclusive Benefit Rule, 55 U. Chi. L. Rev. 1105 (1988), where Fischel and Langbien, on the very first page of their article, say:

> "The overbroad preemption provision has wreaked aimless interference upon state regulation of areas such as health insurance that are quite peripheral to pension policy. Neither a substantial string of Supreme Court cases nor occasional Congressional repair has been able to cure the mess."

Id. at 1105-06 (footnotes omitted).

To the same effect is Irish & Cohen, ERISA Preemption: Judicial Flexibility and Statutory Rigidity, 19 Mich. J. of L. & Reform 109 (1985), where these two critics say:

> " For courts to determine not only that state laws have been preempted but also how and whether to fill in gaps created by preemption, they must develop a common, coherent understanding of why state laws have been preempted. Were the basis for ERISA preemption similar to the broad principles of federalism set out by Justice Frankfuter in the Garmon case [359 U.S. 236 (1959)] then it would be clear that state laws, even if preempted, remain an important source of policy in crafting federal common law to fill the void. If preemption were limited to the subject matters ERISA covers, then it would be resonable to infer that state laws should be respected only where Congress remain silent in ERISA. When all the state laws that have any relation to benefit plans are preempted by willy nilly, however, regardless of whether their purpose and subject matter are complementary to ERISA, it is hard for courts to craft a reasoned

> basis on which to reverify appropriate and compatible state policies through the creation of a federal common law of benefit plans. The problem with Section 514(a) plans, succinctly stated, is that it drains the preemption doctrine of both rationale and flexibilty, implying that any law from a non-federal source is simply not relevant to benefit plans."

Id. at 157 (emphasis in original).

There would be no reason for evolving a "federal common law" if all possible remedies are expressly set forth in the ERISA language itself, and if all others are precluded. For the court to fashion a "federal common law," the courts must look, like all common law courts do, to what other courts have historically fashioned in response to particular societal needs. It matters not whether the "federal common law" is found by a conversion of state remedies into ERISA remedies as the District Court here did (see Appendix "B"), or by looking

to logic and tradition for remedies appropriate to a particular fact situation but not expressly described in the ERISA statute.

Many Courts, throughout the Federal Judiciary, seeing the wrongs being perpetrated against employees/beneficiaries of insurance plans, have anticipated subsequent expressions of Congressional intent and Supreme Court interpretation, that will enable the Courts to create Federal common law under ERISA to provide for full and complete compensatory damages and under appropriate circumstances punitive damages to thwart similar future wrongs. In Armbuster v. Benefit Life Ins. Co., 687 F.Supp. 403 (N.D., Ill. 1988), a district judge cited Belasco v. WKP Wilson & Sons, Inc., 833 F.2d 277 (11th Cir. 1987), for the proposition that "a common law action

displaced by a federal statute ... arises under that statute [ERISA] ..." 687 F.Supp. at 405. In Cedar Rapids Ped. Cl. P. P. v. Continental Assur. 90 F.Supp. 792 (W.D. Ark. 1988), the district judge felt precisely as the Eleventh Circuit did in Belasco v. WKD Wilson and Sons, Inc., 833 F2d 277 (11th Cir 1987), and as the Supreme Court suggested in Bruch, correctly interpreting Dedeaux as follows:

> "Essentially, the plaintiffs contend that what might ordinarily be considered state common-law claims are in fact now federal common-law claims, having been incorporated common-law because of the "comprehensive" protection intended by ERISA "to promote the interests of employees and their beneficiaries in employee benefit plans." Shaw, 463 U.S. at 90, 103 S.Ct. at 2896. In support, they cite Kuntz v. Reese, 760 F.2d 926 (9th Cir. 1985), vacated on other grounds, 785 F.2d 1410 (9th Cir. 1986) (per curiam), cert. denied, 479 U.S. 916, 107 S.Ct. 318, 93 L.Ed. 2d 291 (1986).
>
> In Kuntz, the court found that a

state common law claim for misrepresentation was preempted by ERISA. Id. at 935. See also, Anderson v. John Morrell and Co., 830 F.2d 872, 875 (8th Cir. 1987), and Dependahl v. Falstaff Brewing Corp., 653 F.2d 1208, 1215 (8th Cir. 1981), cert. denied, 454 U.S. 968, 102 S.Ct. 512, 70 L.Ed.2d 384 (1981).

The court also found, however, that the plaintiffs' allegations of misrepresentation stated a claim for breach of fiduciary duty under ERISA. Kuntz, 760 F. 2d at 935; see also, 29 U.S.C. Section 1104(a)(1). As a practical matter, the effect of finding certain state common-law causes of action preempted, but then holding that the allegations as to those causes of action are sufficient to state a claim under ERISA seems to be only that the number of separate fact questions to be answered at trial would be reduced. Certainly, the court in Kuntz did not hold that the allegations in question stated federal causes of action separate from those under ERISA, and if that is the argument the plaintiffs are making here, this court decline to accept it.

However, following the reasoning used in Kuntz, this court finds that the plaintiffs' allegations as to common-law claims based on breach of contract and negligence state a claim under ERISA for

> breach of fiduciary duty. See 29 U.S.C. Section 1104(a). The court further finds that the plaintiffs' allegations as to common-law based on fraud, con-version, breach of fiduciary duty, right to an accounting, and conspiracy, state a claim under ERISA either for breach of fiduciary duty, taking into consideration the plaintiffs' allegations as to agency, see 29 U.S.C. Section 1104(a), or for breach of duty by a co-fiduciary, see 29 U.S.C. 1105(a), or both.
>
> For the reasons discussed, the court holds, therefore, that although state common-law claims are preempted under ERISA and will be dismissed as state claims, the court will not strike the allegations in counts 4-11 of plaintiffs' first amended complaint or those in paragraphs 30-43 of the complaint of intervening plaintiff F & M Pension Plan, but instead will construe those allegations as descriptive of the claims that can admittedly be brought under ERISA."

690 F. Supp. at 795-96.

The Sixth Circuit on April 10, 1989, in Perry v. P*I*E Nationwide, Inc., 872 F.2d 157 (6th Cir. 1989), held that preemption should apply to state law claims only if Congress had provided in ERISA a remedy for

any historically legally recognized wrongs asserted. Also, the Ninth Circuit recently held that the liquidated damage provision of ERISA does not pre-empt alternative contractual remedies formerly available under federal common law. Idaho Plumbers and Pipe Fitters Health and Welfare Fund v. United Mechanical Contractors, Inc., 1989 WL 470 84 (9th Cir. May 9, 1989). See also, Graves v. Blue Cross of California, 688 F.Supp. 1405, 1413 (N.D. Cal. 1988) (ERISA does not pre-empt claims brought pursuant to the California Insurance Code).

A very important case was decided by the Eastern District, New York on March 30, 1989, Mendez-Bellido v. Board of Trustees of Div., 1181, F. Supp, Case No. 87CV3000 (ED. N.Y. 1989). It held that ERISA did not preempt a New York law prohibiting a killer from profiting from his crime and said that

despite the absence of such a defense in ERISA, a pension plan could take advantage of a New York law to avoid paying death benefits to a beneficiary convicted of having killed the insured. What sauce is for the goose should be sauce for the gander. If a traditionally well understood principle of law, Congress recognized as good public policy, can protect an insurer, why should ERISA wipe out all traditional, well understood remedies for wrongs by insurers just short of murder? The petitioners' submit that the Federal Judiciary is not only empowered but entitled to create federal common-law under ERISA in order to effectuate the intent, purpose, and policy of ERISA, which will, among other things, protect the interest of beneficiaries and/or employee benefit plans by developing a body of law to deal with the

issues involving rights and obligations under the medical insurance plans obtained through the beneficiary's employers. This entails the power to convert the state law theory of breach of contract, bad faith, fraud in the inducement, etc., into federal common-law under ERISA so as to provide the wronged beneficiary full compensation for all the injuries, damages and losses suffered as well as in the appropriate case, punitive damages in order to thwart similar wrongs in the future. It is undisputed that the central policy goal of ERISA is to protect the interst of employees and their beneficiaries and the employee benefit plan. 29 U.S.C. Section 10001, et. seq.; Nachwalter v. Christy, 805 F.2d 956, 960 11th Cir. 1986), citing Shaw v. Delta Airlines, Inc., 463 U.S. 85, 103 S.Ct. 2890 (1983). It is undisputed that the

Federal Judiciary is empowered by ERISA to create federal common-law under ERISA in order to effectuate the intent, purpose and policy under ERISA. Helms v. Monsanto Company, Inc., 728 F.2d 1416 (11th Cir. 1984). The Eleventh Circuit stated:

> "However, under ERISA's legislative scheme, this court is empowered to formulate rules law to govern various aspects of the employee benefit field." As Congress pointed out,"It is also intended that a body of law will be developed by the court to deal with the issues involving rights and obligations under the private welfare and pension plan." 120 Cong.Rec. 515, 751 (Daily Ed. August 11, 1974). "Yet, in formulating these laws the court must be guided by the general policies underlying ERISA. The general objective of this act is to increase the number of individuals in employee finance benefit plans. Congress wanted to assure that those who participate in the plans actually receive the benefits that they are entitled to and do not lose these as a result of unduly restricted provisions or lack of sufficient funds." H.R.R.E.P. No. 93-807, 93rd Cong. 2d Sess. 3,

reprinted in 1974 U.S. Code Cong. and Ad. Nw 4639, 4670, 4676-77.

Also see, the comments of Senate Sponsors of ERISA wherein, Senator Javits, one of the two principal Senator sponsors of ERISA stated:

> "It is also intended that a body of federal substantive law will be developed by the courts to deal with obligations under private welfare and pension plans." 120 Cong. Rec. 19,942 (1974) (remarks of Senator Javits).

Likewise, the other Senate Sponsor, Senator Williams, Committee Chairman of the Senate Committee on Labor and Public Welfare, emphasized that suits involving beneficiaries' rights:

> "Will be regarded as arising under the laws of the United States, in similar fashions with those brought under Section 301 of the Labor Management Relations Act." 120 Cong.Rec. 29,933 (1974) (remarks of Senator Williams). Section 301 of the Labor Management Relations Act, "Expressly authorizes the

> federal courts to look at the legislation and fashion a remedy to effectuate the policy thereof." Textile Workers v. Lincoln Mills, 353 U.S. 488, 451, 77 S.Ct. 912, 915, 918, 1 L.Ed.2d 972 (1957).

It is undisputed that federal courts are not restricted by ERISA in the development of remedies to effectuate the policy of ERISA. Thus, the question arises whether the federal judiciary will fulfill its responsibility and develop federal common law under ERISA that will provide full and complete compensation to wronged beneficiaries and under the appropriate circumstances punitive damages to thwart similar wrongs in the future. It is clear, that the legislative history shows Congress intended to incorporate into ERISA federal principals of the law of trust. Under trust law, the duty of the fiduciary flows directly to the

beneficiary of the trust. Although, the remedy of a beneficiary against a defaulted or negligent trustee is ordinarily in equity, "the beneficiary is entitled to all re-dress for harm caused by the breach of a duty arising from the relation." The Re-Statement of Torts Section 874, at (b) (1979) VIOLATION OF FIDUCIARY DUTY. Therefore, a fiduciary is not shielded from redress for his wrongs whether his wrongs have been negligent or intentional and full compensatory damages as well as punitive damages in the appropriate case maybe assessed against a trustee for his wrongs, in order, to insure and effectuate full and complete justice. The Eleventh Circuit Court of Appeals' panel that heard this cause has as aforesaid, made request for this Honorable Court to give a clear direction that will enable the federal

judiciary, including, but not limited to, the Eleventh Circuit Court of Appeals to begin the development of federal common law under ERISA that will provide full and complete compensation to the victims of various wrongs perpetrated as against them by the insurance industry and/or by the employer and where appropriate the sanctions of punitive damages to thwart similar wrongs in the future.

This is the best case to come before this Honorable Court with respect to the question of whether or not the federal judiciary has the obligation to develop federal common law under ERISA so as to provide for full and complete compensatory damages and where appropriate, punitive damages, so as to provide a remedy for wrongful conduct not otherwise provided for in the presently existing ERISA statutes.

This case, clearly presents the issue of what "preemption" actually means and whether or not federal common law may be developed under ERISA as aforesaid, unclouded by significant extraneous questions such as whether or not the wording of a specific ERISA statute or statutes provide for such common law development under ERISA. At this stage in this cause, neither the factual or legal issues preclude review. Respondents for the purpose of allowing them to appeal, the U. S. District Judge's Order, have admitted all the factual issues are virtually uncontested and thus, admitted their fraud, and other wrongful conduct. The respondents' position is that ERISA gives them a license to take whatever action they desire, whether wrongful or not, and immunizes them so that they would only have to pay those benefits that should have been

paid in the first place, interest and if the trial court so orders, in its discretion, then the attorney's fee so that the wrongdoers will not have to pay full and complete compensatory damages proximately caused from their wrongful acts and/or under the appropriate circumstances, suffer the sanctions of punitive damages.

The decision of the Court of Appeals should be reviewed because it presents a clear opportunity to instruct the lower courts on an increasingly important question. Earlier decisions and the decision of the Eleventh Circuit below must be reviewed in light of the new legislative intent expression as aforesaid. Petitioners are aware that the Supreme Court of Alabama has decided on July 21, 1989 an appeal, to-wit: HealthAmerica v. Edward Menton, No. 87-1100, _____So. 2d _____, (see Appendix D) which involves the same or similar

issues. Alabama's highest court has instructed the Alabama courts which have concurrent jurisdiction over ERISA governed cases, contrary to the Eleventh Circuit, and thus an intolerable situation exist. This Honorable Court will quickly see that HealthAmerica is in direct conflict with the opinion of the Court of Appeals for the Eleventh Circuit in Amos v. Blue Cross, as to which petitioners have asked this Court to direct a Writ of Certiorari. There is no Court except the Supreme Court of the United States which can resolve the sharp and obvious difference of opinions between the state and federal courts in Alabama over the meaning of Dedeaux and "preemption" in ERISA cases.

CONCLUSION

Premises considered, plaintiffs-appellees-petitioners respectfully request

this Court to issue a Writ of Certiorari to the Court of Appeals for the Eleventh Circuit and to accept this case for review.

This will enable this Honorable Court to give guidance to all federal judges and state judges with respect to the creation of common-law under ERISA that will provide full and complete compensation to the victims of the wrongful acts of the insurance industry and the employers and, where appropriate, sanctions of punitive damages to thwart similar wrongs in the future. Anything less would as the Eleventh Circuit said, constitute the removal of historical disincentives to insurance company misbehavior which was not intended by ERISA as evidenced by the aforementioned Congressional intent/history.

Respectfully submitted,

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Of Counsel:

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CERTIFICATE OF SERVICE

This is to certify that I have this date served a copy of the foregoing upon the Honorable Lawrence B. Clark, Sally S. Reilly, Duncan B. Blair, 1700 First Alabama Bank Building, Birmingham, Alabama 35203.

This the 2nd day of ~~July~~ Aug, 1989.

DANIEL B. KING

APPENDIX A

Harley AMOS and Gail Amos,
Plaintiffs-Appellees,

v.

BLUE CROSS-BLUE SHIELD OF ALABAMA and
Jan Cullinghan, Defendants-Appellants.

No. 88-7287

United States Court of Appeals,
Eleventh Circuit.
March 24, 1989.

Rehearing and Rehearing In Banc
Denied May 5, 1989

Beneficiaries brought state court actions to recover money allegedly due and owing them under employee benefit plans, and cases were removed to federal court under ERISA. The United States District Court for the Northern District of Alabama, No. 87-AR-1644-M, William M. Acker, Jr., J., 676 F.Supp. 1119, struck beneficiaries demand for jury trial and, at 681 F.Supp.

1515, denied motion for reconsideration and determined that pendant state law claims could be tried as ERISA claims with possibility of punitive damages. On appeal, the Court of Appeals, held that effect of ERISA preemption is to wholly eliminate state law claims by employee benefit plan beneficiaries, leaving beneficiaries only causes of action specially provided for in ERISA civil enforcement provisions, rather to "absorb" state law claims, allowing them to proceed unaffected in substance by conversion, and thus, preemption eliminates possibility of punitive or extra-contractual damages provided by state law.

Reversed and remanded.

Pensions--Key 22 States--Key 18.51

Effect of ERISA preemption is to wholly eliminate state law claims by employee benefit plan beneficiaries, leaving

beneficiaries only causes of action specially provided for in ERISA civil enforcement provisions, rather than to "absorb" state law claims, allowing them to proceed unaffected in substance by conversion, and thus, preemption eliminates possibility of punitive or extracontractual damages provided by state law. Employee Retirement Income Security Act of 1974, Sections 502(a)(3), 514, 29 U.S.C.A. Sections 1132(a)(3), 1144.

Lange, Simpson, Lawrence B. Clark, Sally S. Reilly, Duncan B. Blair, Robinson & Somerville, Birmingham, Ala., for defendants-appellants.

Robert H. King, Daniel B. King, King & King, Gadsden, Ala., for plaintiffs-appellees.

Appeal from the United States District Court for the Northern District of Alabama.

Before FAY and ANDERSON Circuit Judges, and HENDERSON, Senior Circuit Judge.

PER CURIAM:

This action arises out of the alleged wrongful denial of claims for benefits under an employee benefit plan as defined by the Employee Retirement Income Security Act of 1974, 29 U.S.C. Section 1001, et seq. (1982) ("ERISA"). The plaintiffs, Harley and Gail Amos, originally brought this action in an Alabama state court against defendants Blue Cross-Blue Shield of Alabama as underwriter of the plan and Jan Cullinghan, an employee of Blue Cross (collectively, "Blue Cross"). The complaint asserted various state law violations including fraud and bad faith refusal to pay and sought extra-contractual compensatory and punitive damages. Blue Cross immediately removed the action to the United

States District Court for the Northern District of Alabama.

In November, 1987, Blue Cross filed a motion to strike claims for damages other than the contractual benefits sought in the plaintiffs' amended complaint, alleging that, under ERISA, extra-contractual and punitive damages are not recoverable as a matter of law. The district court denied Blue Cross' motion, 676 F.Supp. 1119, and leave to appeal that order subsequently was denied by this court in February, 1988. On March 9, 1988, Blue-Cross filed a motion for reconsideration of the order denying its motion to strike. That motion was denied. 681 F.Supp. 1515. This court, on May 11, 1988, granted Blue Cross' petition for leave to appeal the trial court's interlocutory order denying Blue Cross' motion for reconsideration. The parties agree that

this case involves a purely legal question and that there are no facts other than those set forth above which are relevant to the issue on appeal.

The issue in this case is whether the effect of ERISA preemption-which, at least for purposes of removal jurisdiction, converts state law causes of action into federal questions-is to completely eliminate state law causes of action relating to an ERISA plan, or whether ERISA pre-emption operates to "absorb" state law claims, allowing them to proceed unaffected in substance by the conversion. We hold that ERISA preemption is not a gateway but a barrier to state law causes of action, the effect of which is to completely displace state law claims. Accordingly, we reverse the district court's judgment.

ERISA comprehensively regulates, among

other things, employee welfare benefits plans that, "through the purchase of insurance or otherwise," provide such benefits as, for example, insurance coverage for medical, surgical, or hospital care, or the payment of sums in the event of sickness, accident, disability or death. 29 U.S.C. Section 1002(1); Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 44, 107 S.Ct. 1549, 1551, 95 L.Ed.2d 39, 46 (1987).[1] ERISA contains six civil enforcement provisions, section 1132(a)(1)-(6), which set forth the remedies available to participants, beneficiaries, fiduciaries and the Secretary of Labor against all parties that fail to comply with the statute's dictates. However, the various types of relief available

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[1] The parties do not dispute that plaintiffs are beneficiaries of an ERISA plan.

to plaintiffs in civil actions brought pursuant to ERISA's civil enforcement scheme do not include extra-contractual or punitive damages. Massachusetts Mut. Life Ins. Co. Russell, 473 U.S. 134, 148 105 S.Ct. 3085, 3094, 87 L.Ed.2d 96, 107 (1985); Bishop v. Osborn Transp., Inc., 838 F.2d 1173, 1174 (11thCir), cert. denied, ___U.S.___, 109 S.Ct. 90, 102 L.Ed.2d 66 (1988).[2] Thus, the plaintiffs cannot obtain the relief they seek here by pursuing a cause of action arising under ERISA. Rather, they are entitled to punitive damages only if some alternative theory of recovery grounded in state law is available to them.

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[2]Although plaintiffs steadfastly maintain that the issue regarding whether punitive damages are available in civil actions brought pursuant to Section 1132(a)(3) has not been conclusively settled, the Eleventh Circuit, following the lead of a half dozen other circuits, has unequivocally answered that question in the negative. Bishop, 838 F.2d at 1174.

section 1132(a)(1)-(6), which set forth the remedies available to participants, beneficiaries, fiduciaries and the Secretary of Labor against parties that fail to comply with the statute's dictates. However, the various types of relief available to plaintiff's in civil actions brought pursuant to ERISA's civil enforcement scheme do not include extra-contractual or punitive damages. Massachusetts Mut. Life Ins. Co. v. Russell, 473 U.S. 134, 148, 105 S.Ct. 3085, 3094, 87 L.Ed.2d 96, 107 (1985); Bishop v. Osborn Transp., Inc., 838 F.2d 1173, 1174 (11th Cir.), cert. denied, _____U.S._____, 109 S.Ct. 90, 102 L.Ed.2d 66 (1988). Thus, the plaintiffs cannot obtain the relief they seek here by pursuing a cause of action arising under ERISA plans. 29 U.S.C. Section 1144. Generally, if a state law relates to employee benefit plans,

it is preempted, although a saving clause excepts from the preemption provision state laws which regulate insurance. Dedeaux, 481 U.S. at 45, 107 S.Ct. at 1552, 95 L.Ed.2d at 46. In the instant case, there can be no dispute that the common law causes of action asserted by the plaintiffs--bad faith refusal to pay, fraud and breach of contract--"relate to" an employee benefit plan and therefore fall within ERISA's express preemption clause. See id. at 47, 107 S.Ct. at 1553, 95 L.Ed.2d at 47-48. Also above question is that the plaintiffs' state law causes of action are not excepted from ERISA preemption. See id. at 57, 107 S.Ct. at 1558, 95 L.Ed.2d at 54.

Blue Cross maintains that the effect of ERISA preemption is to wholly eliminate state law claims, leaving plaintiffs only the causes of action expressly provided for

in the ERISA civil enforcement provisions. Blue Cross' position would be impregnable were it not for a single sentence in one of this court's opinions. In Belasco v. W.K.P. Wilson & Sons, Inc., 833 F.2d 277, 282 (11th Cir. 1987), this court, discussing whether removal was proper where plaintiffs' complaint raised only claims provided by state laws relates to an ERISA plan, wrote that "ERISA pre-emption does not act as a defense to a state-law claim, which is the usual effect of federal pre-emption; instead, ERISA pre-emption converts the related claim into a federal question." In so stating, this court followed the Supreme Court's decision in Metropolitan Life Ins. Co. v. Taylor, 481 U.S. 58, 107 S.Ct. 1542, 95 L.Ed.2d 55 (1987). In that case, the Court held that the preemptive force of ERISA is so powerful that it completely

displaces state law claims. As a result, a cause of action which relates to an ERISA plan, though it purports to be grounded in state law, "is necessarily federal in character by virtue of the clearly manifested intent of Congress" and is removable to federal court. Taylor,, 481 U.S. at 67, 107 S.Ct. at 1548, 95 L.Ed.2d at 65.

The plaintiffs observe that neither the opinion in Taylor, nor the one in Belasco, addressed the question of the disposition of a state law claim following removal into federal court. They contend that the state law causes of action survive, permitting the recovery of such damages as would be available under the state substantive law. Blue Cross takes the position that the conversion of state law claims into federal questions described by the courts in Taylor and Belasco operates only to supply federal

question removal jurisdiction. In this latter view, the state law causes of action do not thereafter provide alternative avenues to relief not mapped out in ERISA.

The plaintiffs' argument is a creative one, but there is little law to sustain it. The district court's opinion effectively argued the cause but misread Belasco and Bishop. Moreover, the district court sidestepped the Supreme Court's decisions in Dedeaux and Taylor, and its reasoning has been undercut by a case subsequently decided in this court, Anschultz v. Ct. Gen. Life Ins. Co., 80 F.2d 1467 (11th Cir. 1988). In Anschultz, the court, following Dedeaux, affirmed the district court's order granting summary judgment in favor of the insurance company defendant on the ground that ERISA preempted the plaintiff's state common law and statutory claims. Id.

at 1469 ("Where otherwise applicable, ERISA preempts all state law"). The plaintiff, seeking both compensatory and punitive damages based upon the alleged wrongful denial of long term disability benefits under a group insurance policy governed by ERISA, had originally filed his action in a Florida state court, and the defendant later removed the case to the federal district court. Although the Eleventh Circuit Court of Appeals in Anschultz may not have been asked to consider the effect of Belasco on the survival of a state claim following removal (indeed, the Belasco opinion is not cited in Anschultz), the court's holding implicitly rejected the notion that the state law claims continued to be viable.

Similarly, in Dedeaux, upon which this court principally relied in Anschultz, the Supreme Court upheld the district court's

grant of summary judgment in favor of the defendant insurance company on the ground that the plaintiff's common law claims were preempted by ERISA. True, in Dedeaux the plaintiff originally had instituted the action in the district court on the basis of diversity of citizenship, and thus the Court did not need to consider the effect of the conversion of state law claims into federal questions. But it would be strange if the initial choice of forum were dispositive of the preemptive effect of ERISA. Rather, it would seem that to permit a state claim to continue following removal of a federal court would be contrary to the Dedeaux and Anschultz decisions, notwithstanding that under Taylor and Belasco such causes will survive preemption long enough to form the basis for federal question jurisdiction.

Accordingly, we are compelled by

controlling precedent to reverse the judgment of the district court. We acknowledge that by eliminating the possibility that insurance companies may be liable for punitive or extra-contractual damages, the courts are removing an historical disincentive to insurance company misbehavior. Consequently, our decision may produce unintended results. However, any change in the law's course will have to be charted by the Congress or the Supreme Court.

REVERSED and REMANDED.

APPENDIX B

Harley AMOS, et al., Plaintiffs

v.

BLUE CROSS-BLUE SHIFLD OF ALABAMA
et al., Defendants

Civ. A. No. 87-AR-1644-M

United States District Court,
N.D. Alabama, M.D.
March 22, 1988.

On motion for reconsideration in an ERISA case, the District Court, Acker, J., held that pendent state law claims of pension plan beneficiaries continued as viable ERISA claims by "absorption," and could be tried as ERISA claims with the possibility of punitive damages, notwithstanding claim that beneficiaries were limited to recovery of benefits to which they might be entitled under the plan.

Motion denied.

Federal Courts--Key 15

Pendent state law claims of pension plan beneficiaries continued as viable ERISA claims by "absorption," and could be tried as ERISA claims with the possibility of punitive damages, notwithstanding claim that beneficiaries were limited to recovery of benefits to which they might be entitled under the plan. Employee Retirement Income Security Act of 1974, Section 2 et seq., 29 U.S.C.A. Section 1001 et seq.

Daniel B. King, Robert H. King, Sr., King & King, Gadsden, Ala., for plaintiffs.

Lawrence B. Clark, Sally S. Reilly, Lange, Simpson, Robinson & Somerville, Birmingham, Ala., for defendants.

MEMORANDUM OPINION

ACKER, District Judge.

Defendants, Blue Cross-Blue Shield of

Alabama and Jan Cullighan (Blue Cross), have moved for a reconsideration of this court's ruling of December 30, 1987, which held that the pendent state law claims of plaintiffs, Harley Amos and Gail Amos, continue as viable ERISA claims, by absorption, as a consequence of the Eleventh Circuit's opinion in Belasco v. W.K.P. Wilson and Sons, Inc., 833 F.2d 277 (11th Cir. 1987), decided on December 2, 1987, by a panel consisting of Judges Hill, Hatchett and Thomas. Blue Cross now cites, with understandable relish, Bishop v. Osborn Transportation, Inc., 838 F.2d 1173 (11th Cir.1988), decided on March 1, 1988. In Bishop, this very court was affirmed by an Eleventh Circuit panel consisting of Judges Hill, Fay and Hatchett, who there deduced, despite the deliberately equivocal opinion of the Supreme Court in Massachusetts Mutual

Ins. Co. v. Russell, 473 U.S. 134, 105 S.Ct. 3085, 87 L.Ed.2d 96 (1985), that punitive damages cannot be recovered under the Employee Retirement Income Security Act of 1974, 29 U.S.C. Section 1132(a) (ERISA), thus apparently solving the problem, as far as the Eleventh Circuit is concerned, which had been reserved in Howard v. Parisian, Inc., 807 F.2d 1560, 1565 (11th Cir. 1987).

In its motion for reconsideration, Blue Cross makes very clear its position that "plaintiff is not entitled to damages beyond the benefits to which he may be entitled under the employee welfare benefit plan of which he is a participant." In its brief Blue Cross also makes clear its further position that a trustee or plan administrator cannot even be held liable for benefits unless his decision to turn down a claim is "arbitrary and capricious," i.e.,

totally irrational or in bad faith.

The question to be revisited here concerns the extent to which the national public policy enacted in ERISA narrows the exposure of the trustees of welfare benefits funds and plan administrators. Does it close the door against all meritorious tort-type claims by plan beneficiaries? If the recognized purpose of ERISA was to protect beneficiaries, will this "new dispensation," by judicial construction, take away all of the effective traditional remedies of the beneficiaries? Would Blue Cross carry its argument so far as to suggest that ERISA wipes out a plan beneficiary's state tort claim arising out of his administrator's running over him with a truck in his driveway while attempting to deliver a benefit check? This activity would be directly related to the administration of

the plan. It very arguably comes within the "supersedure" of 29 U.S.C. Section 1144(a). Where is the line to be drawn? It is provocative to note that there is now a petition on this subject pending in the Supreme Court for certiorari to the Third Circuit in Continental Group, Inc. v. McLendon, No. 87-911 (3rd Cir.1987), decided by the Third Circuit on November 11, 1987. In Continental Group, the Third Circuit dealt with the serious problem of preserving a party's constitutional right to jury trial in an action which combines legal and equitable claims, certain of them admittedly being ERISA claims. The law as to the breadth of ERISA preemption and as to the right to jury trial in ERISA or ERISA-related claims remains highly volatile, conflicting and undefined. For instance, in Schlenz v. United Airlines, 678 F. Supp.

230 (N.D.Cal.1988), decided as recently as January 19, 1988, Judge Henderson found that a former employee's pendent state law claims for wrongful discharge and breach of contract against his employer are not preempted by ERISA. See also Hickman v. Tosco Corp., 840 F.2d 564 (8thCir.1988). These decisions square with this court's reading of Belasco although the rationale is different. In Schultz v. National Coalition of Hispanic Mental Health & Human Services, 678 F.Supp. 936, (D.D.C.1988), decided on February 11, 1988, Judge Richey held that a former employee's action for fringe benefits lost when plaintiff allegedly was illegally terminated, does not create a ground for ERISA preemption of the employee's state law discrimination claim. Again, Schultz can be reconciled with Belasco by recognizing that the two courts arrived at the same result by

using different semantic routes. Both routes leave the court door ajar for remedies beyond mere U.S. _____, 107 S.Ct. 2211, 96 L.Ed.2d 1 (1987), in which a divided Supreme Court decided that the enforcement of a particular law of Maine, although it directly involved employment benefits in the context of severance pay, is not preempted by ERISA, because it does not "relate to any employee benefit plan." 29 U.S.C. Section 1144(a). The majority expanded this rationale by articulating several reasons why Maine's cause of action is not precluded by ERISA. Without here repeating these reasons, several of them could well be used to characterize the state law claims which were originally presented by Mr. and Mrs. Amos and are now "converted."

If ERISA was congressionally designed

to eliminate any and all causes of action against pension trustees and plan administrators not expressly found within the four corners of ERISA, not only are overlapping state claims precluded but a federal cause of action under the Age Discrimination in Employment Act of 1967, 29 U.S.C. Section 621-634, even though arising out of many of the same operative facts, if "related to any employee benefit plan," would be precluded. How exclusive did Congress intend for ERISA to be?

Blue Cross likes the sound of Rasmussen v. Metropolitan Life Ins., 676 F.Supp. 1360 (W.D.La. 1988), decided on January 21, 1988, in which Judge Stagg stated the extreme belief that not only does ERISA preempt (in the sense of "eliminate") all state law claims but that a plan beneficiary cannot even go to court to invoke ERISA by

claiming that the administrator was "arbitrary and capricious" until he has exhausted all administrative remedies provided by his plan. Other courts have held the same thing. The looming possibility of having to submit to the binding arbitration of an already tightly circumscribed ERISA claim (limited, if Blue Cross is correct, to a bare claim for benefits), is again suggested by Printing Specialty Local 680 v. Nabisco Brands, 833 F.2d 102 (7th Cir.1987). Printing Specialty necessarily implies that if a pension plan contains a provision requiring binding arbitration, resort to court is forever precluded unless there is some way to attack the arbitrator's finding. In other words, if Blue Cross can take the step off "eliminating them entirely," as contrasted with the Belasco sense of "converting them

into ERISA claims," then Blue Cross would no doubt want to take the next logical step and introduce into its various plans a binding arbitration provision. It would be ironic, indeed, for a beneficiary who becomes the victim of monumental fraud or of classically abusive behavior by a plan administrator not only to be limited to a recovery of benefits clearly due under the terms of his contract (with all ambiguities to be resolved in favor of the administrator), but if the plan requires it, to submit the issue of whether or not the administrator was "arbitrary and capricious" to binding arbitration, thus, as a practical matter, eliminating entirely the beneficiary's access to court. From the point of view of reducing this court's case load, this scenario would produce a highly desirable result. It would be the reverse bootstrap working at its best.

A puzzle is presented by the fact that Bishop, decided on March 1, 1988, makes no mention of Belasco, decided on December 2, 1987. Therefore, Bishop does not attempt to distinguish Belasco or to reconcile the two expressions on the same subject only three months apart. If the two panels had not contained two of the same judges, this court might reason that the Bishop court was unaware of the Belasco decision, but the fact that two of the same judges participated in both decisions makes this reasoning impossible. The matter is further complicated by the fact that on February 24, 1988, Judges Tjoflat and Edmondson, in the instant case, denied Blue Cross' application for an interlocutory appeal from this court's order of December 30, 1987, which recited this court's interpretation of Belasco, as follows:

> This court finds it impossible to read this language [Belasco, p. 281-82] spoken less than a month ago by the Eleventh Circuit for anything except what it literally means, namely that while ERISA does preempt state tort claims it effects that preemption not by eliminating the state tort claims but by absorbing them and allowing them to proceed as federal claims, either as matter of federal common law or as matters within the contemplation of the ERISA statutory language. Belasco answers the question reserved in Howard v. Parisian, Inc., 807 F.2d 1560, 1565 (11th Cir.1987).

By denying the interlocutory appeal, were Judges Tjoflat and Edmondson postponing the Eleventh Circuit's addressing of the meaning of Belasco, or were they suggesting agree-

ment with this court's reading of Belasco? At the time this court spoke on December 30, 1987, Bishop had not been decided. Bishop was still around the corner. The question is: Does Bishop call upon this court to alter its interpretation of Belasco?

If there is a logical way of a lower court to reconcile arguably contradictory expressions by a binding appellate court, the lower court certainly has a duty to do so. This court, therefore, now undertakes to prevent Bishop from contradicting Belasco.

In Bishop, the plaintiff sought punitive or extracontractual damages under ERISA. The Eleventh Circuit was not asked in Bishop to rule on the question of preemption of state law claims. Therefore, it had no reason to discuss the possible metamorphosis of the ugly-cater-

pillar-state-law-claims, a la Belasco, into beautiful-butterfly-ERISA-claims. The discussion in Bishop centered exclusively around the ERISA relief includable as "other appropriate equitable relief" under 29 U.S.C. Section 1132. If a pendent state tort claim for a fraud perpetrated by a plan administrator or trustee, or a state tort claim for a bad faith refusal to pay a clearly due claim, is "converted" into a federal question by ERISA "preemption," as the Eleventh Circuit defined "preemption" in Belasco, 833 F.2d 282, this "conversion" is meaningless if the beneficiary can recover by way of the benefits clearly due by contract. This court thus can only conclude that Bishop was decided on the narrow basis that the plaintiff there only presented the question of the definition of "other appropriate equitable relief," and did not

seek to enjoy the opening afforded by Belasco, because he did not know about Belasco and did not anticipate Belasco. This court knows that it had not anticipated Belasco when, as the lower court, it ruled in Bishop.

Blue Cross argues that when the Eleventh Circuit in Belasco announced that "ERISA pre-emption converts the related [state] claim into a federal question," 833 F.2d at 282, the Eleventh Circuit inserted by implication the additional words "for the limited purpose of ascertaining whether or not 'federal question' removal jurisdiction exists." Blue Cross argues that this is the only interpretation of Belasco consistent with the Eleventh Circuit's denial of the right to jury trial in all ERISA cases and consistent with the denial of punitive damages in Bishop. See Whitt v. Goodyear

Tire & Rubber Co., 676 F.Supp. 1119 (N.D. Ala.1987), for this court's feelings on the subject of jury trial in ERISA cases. In order to understand Belasco, it must be remembered that Belasco began just as the instant case began, with a complaint being filed in an Alabama state court alleging, inter alia, "bad faith" and "fraud." 833 F.2d at 279. If the panel in Belasco had only meant that these two garden variety state tort claims are reduced in size or limited to a recovery of the plan benefits contractually due, as is here urged by Blue Cross, the panel would surely have made clear such intention. Instead, the Eleventh Circuit said that these state torts of "bad faith" and "fraud" had been "converted" by ERISA into federal claims. Nowhere did the Court say or imply that this "conversion" was less than total. This

court is forced to take the Eleventh Circuit's opinion in Belasco at face value and to construe it under the rules of English grammar. If the Eleventh Circuit ultimately chooses to agree with Blue Cross, instead of agreeing, in substance and effect, with what the several other courts above cited have recently held, the Eleventh Circuit will, of course, do so when the opportunity presents itself, whether in this case or some other case.

For the present, this court is unwilling to adopt Blue Cross' means for reconciling Belasco and Bishop. Instead, this court prefers the means of reconciliation above employed. It remains to be seen, of course, which means of reconciliation is correct.

Blue Cross' motion for reconsideration will be denied by separate order, and the

Amos' former state law claims, now having become ERISA claims, although not entitling plaintiffs to trial by jury because of Chilton v. Savannah Foods & Industries, Inc., 814 F.2d 620 (11th Cir.1987), will be tried as ERISA claims with a possibility of punitive damages. This court is not unaware of the anomaly arising from the decision of the Supreme Court of Alabama (without considering Belasco or Bishop) when that court recently held that punitive and extracontractual damages are not recoverable under ERISA. Hood v. Prudential Insurance Co. of America, 522 So.2d 265 (1988). Potentially, the Amos' former state tort claims, now ERISA claims, will call for the imposition of punitive damages despite the fact that according to Bishop, ERISA itself, as distinct from state claims converted by ERISA, does not authorize punitive damages.

APPENDIX C

Harley AMOS and Gail Amos,
Plaintiffs-Appellants

v.

Blue Cross-Blue Shield of Alabama,
et al al., Defendants-Appellees.

No. 88-7287

In The United States Court of Appeals
For the Eleventh Circuit

On Petition(s) For Rehearing and
Suggestion(s) of Rehearing in Banc
Denied May 5, 1989

Appeal from the United States District Court
for the Northern District of Alabama.

Before FAY and ANDERSON, Circuit Judges, and HENDERSON, Senior Circuit Judge.

PER CURIAM:

The Petition(s) for Rehearing are DENIED and no member of this panel nor other Judge in regular active service on the Court having requested that the Court be polled on rehearing in banc (Rule 35, Federal Rules of

Appellate Procedure; Eleventh Circuit Rule 35-5), the Suggestion(s) of Rehearing In Banc are DENIED.

APPENDIX D

HealthAmerica and Pamela Merle,

v.

Edward Menton.

No. 87-1100

The Supreme Court of Alabama
Special Term, 1989

Appeal from Mobile Circuit Court
(CV-86-003049)

SHORES, JUSTICE.

The plaintiff/appellee, Edward Menton, was employed as city editor for the Mobile Press Register newspaper ("Press Register"). As part of his employment, Menton was provided with medical insurance coverage, for which the Press Register paid 50 to 60 percent of the premiums and the balance was deducted from Menton's salary.

In June 1985, the Press Register offered an alternative medical benefit selection, which allowed qualified Press Register employees either to keep the medical insurance that they had, or to cancel it and enroll in one of the two health maintenance organizations then in the Mobile area, Prime Health and defendant/appellant, HealthAmerica, without suffering an interruption of benefits.

Menton had a son, Jacob, whose premature birth necessitated a series of surgical operations to lengthen and straighten the tendons in his legs and feet. After each such operation, and after his casts were removed, Jacob would undergo physical therapy treatments three times a week until he was ready for his next surgical operation.

Menton's health insurance under the Press Register's employment benefit plan

paid 80% of the cost of Jacob's physical therapy treatments and orthopedic appliances. Jacob's second operation was imminent when the Press Register employees were offered alternative coverage by either of the health maintenance organizations. HealthAmerica's list of physicians included both of the physician's who had been treating Jacob's legs; Prime Health's did not. Menton read the promotional literature regarding HealthAmerica's coverage but could not determine from that whether Health-America would provide coverage for Jacob's physical therapy and orthopedic appliances.

At the suggestion of the assistant general manager of the Press Register, who had initially reviewed the coverage provided by HealthAmerica and had helped Health-America distribute information about its plan to the Press Register employees, Menton

attended an informational meeting of Press Register employees three days before Jacob's second surgery. This meeting was presided over by defendant/appellant Pamela Merle, who had worked for HealthAmerica for approximately one and one-half months prior to this meeting. During the meeting, the Press Register employees were repeatedly told that the coverage provided by the health maintenance organizations such as HealthAmerica and Prime Health was generally the same as, or was better than, the medical coverage that Menton and other employees had. After the meeting, Menton asked Merle specific questions about HealthAmerica's coverage of Jacob's medical expenses. He explained Jacob's medical history, his impending operation, and his need for extensive physical therapy and orthopedic appliances after his second surgery. In response to a

direct question from Menton, Merle informed Menton that Jacob's medical expenses would be "covered one hundred percent by Health-America."

In reliance upon Merle's representations, Menton dropped his health insurance and enrolled in the HealthAmerica plan. After Menton enrolled in the HealthAmerica plan, he received a schedule of benefits in the mail. On reviewing the schedule, Menton noticed that outpatient services for physical therapy were apparently covered for only 60 days. Menton attempted to get HealthAmerica to provide the coverage that he had been promised when he dropped his previous insurance, which provided coverage for 80% of Jacob's physical therapy expenses for an unlimited period of time. Health-America extended coverage for 60 additional days after the initial 60-day period, but

would not provide coverage beyond that. Jacob's physical therapy expenses amounted to approximately $150 a week.

Menton filed this suit against Health-America and its agent, Merle, in which he alleged a state common law action for fraud, asserting misrepresentations of a material fact made willfully to deceive, or recklessly without knowledge caused him to drop the hospital coverage he had under an insured employment benefit plan and to elect the HealthAmerica coverage also provided under the plan. The defendants pleaded the general issue and preemption by the Employment Retirement Income Security Act of 19974 ("ERISA"), 88 Stat. 829 as amended, 29 U.S.C. Section 1001 et seq. Menton did not file a claim under ERISA. Predicated on the ERISA preemption, the defendants moved for a directed verdict at the close of Menton's

case and at the close of all the evidence. The trial court observed that the Alabama Health Maintenance Organizations Statutes ("HMO Statutes"), Code 1975, Sections 27-21A-1 to 27-21A-32, and the Alabama "twisting" statute, Code 1975, Section 271-2-6, might be saved by section 514(b) of ERISA if Menton's claim were subject to ERISA preemption; overruled the defendant's motions for a directed verdict; and submitted the case to the jury with instructions on Alabama civil actions for misrepresentation, without reference to the HMO statutes or the twisting statute. The jury returned a verdict in favor of Menton. After final judgment was entered, Menton filed a motion to amend his complaint to conform to the evidence, alleging a violation of Section 27-12-6, the "twisting" statute. The defendants' objection to this

was overruled, as was their motion for a judgment notwithstanding the verdict or in the alternative for a new trial.

The first issue presented by this case is whether ERISA preempts a state common law action for fraud where the plaintiff alleges that he relied on misrepresentations made by the defendants in dropping his old hospital insurance and electing coverage under the defendants' plan. We hold that a claim for fraud in the inducement does not "relate to" an employee benefit plan and is therefore not preempted by ERISA.

The courts in Alabama have recognized a common law right of action for fraud, at least since the case of Einstein, Hirsch & Co. v. Marshall & Conley, 58 Ala. 153 (1877), when Justice Stone criticized the old case of Chandelor v. Lopus, 1 Smith Lead. Cas. 319 (9th ed. 1889) (adjudged in

the Court during the Reign of James the First), which involved alleged fraud in the sale of a stone, which the seller represented as a bezoar stone and sold as such. All the Barons, except Anderson, in the Court of Exchequer held that "'the bare affirmation that it was a Bezoar stone, without warranting it to be so, is no cause of action; and although he knew it to be no Bezoar stone, it is not material.'" 58 Ala. at 160 (quoting Chandelor v. Lopus). To this Justice Stone wrote, "We submit, if this language does not sanction looser morals than the present state of the law will justify." 58 Ala. at 160. To make certain that it did not sanction those looser morals of Chandelor v. Lopus, the legislature of Alabama in 1907 codified laws that it had enacted that provided civil actions for fraud (now Code 1975, Section 6-

5-100), for misrepresentations of material fact (now Section 6-5-101), for suppression of material facts (now Section 6-5-102), and for deceit (now Section 6-5-103).

With ERISA, Congress imposed comprehensive federal oversight of employee benefit plans of employers engaged in interstate commerce. Under ERISA Section 502(a), as set forth in 29 U.S.C. Section 1132(a)(1)(B), a civil action may be brought by a participant or beneficiary "to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." This limits the options of the employee, who is pre-empted from bringing actions under the state laws when they "relate to" any employee benefit plan.

ERISA's preemption provision states:

> "Except as provided in subsection (b) of this section [the saving clause], the provisions of this subchapter and subchapter III of this chapter supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan...."

29 U.S.C.A. Section 1144(a).

The defendants argue that Menton is pre-empted under this ERISA preemption provision from filing a state common law action for fraud. Under the facts of this case, the Press Register is engaged in interstate commerce; the undisputed evidence shows that the Press Register solicits advertisements from outside Alabama, advertises for businesses located outside Alabama, and sells its papers outside Alabama. Menton was a full-time employee of the Press Register, and the Press Register had an employee benefit plan prior to and after Menton enrolled in the HealthAmerica plan.

Therefore, we must determine whether his claim is preempted by ERISA. The defendants rely upon Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 107 S.Ct. 1549, 95 L.Ed. 2d 39 (1987), wherein the Supreme Court ruled that a state lawsuit asserting improper processing of a claim for benefits under an ERISA-regulated plan was pre-empted by federal law. In Pilot Life the Supreme Court held that the phrase "relate to" is to be given its "'broad common-sense meaning, such that a state law "relate[s] to" a benefit plan "in the normal sense of the phrase, if it has a connection with or reference to such a plan."'" 481 U.S. at 47, citing Metropolitan Life Insurance Co. v. Massachusetts, infra, and Shaw v. Delta Air Lines, Inc., infra.

The United States Supreme Court had considered ERISA's preemption provision

three times prior to Pilot Life: Alessi v. Raybestos-Manhattan, Inc., 451 U.S. 504, 101 S.Ct. 1985, 68 L.Ed.2d 402 (1981); Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 103 S.Ct. 2890, 77 L.Ed.2d 490 (1983); and Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724, 105 S.Ct. 2380, 85 L.Ed.2d 728 (1985).

In Shaw v. Delta Air Lines, Inc., the Court noted that "[s]ome state actions may affect employee benefits in too tenuous, remote, or peripheral a manner to warrant a finding that the law 'relates to' the plan." 463 U.S. at 100 n.21. In Shaw, the Court cited with approval American Telephone & Telegraph Co. v. Merry, 592 F.2d 118 (2dCir.1979), in which the Second Circuit Court of Appeals held that ERISA did not preempt a state's garnishment of a spouse's benefit plan income to enforce alimony and

support orders. In accord, see, Savings & Profit Sharing Fund of Sears Employees v. Gago,, 717 F.2d 1038 (7thCir. 1983); Howard v. Parisian, Inc., 807 F.2d 1560 (11thCir. 1987); Sommers Drug Stores Co. Employee Profit Sharing Trust v. Corrigan Enterprises, Inc., 793 F.2d 1456 (5thCir. 1986), cert. denied, 479 U.S. 1034, 107 S.Ct. 884, 93 L.Ed.2d 837 (1987).

HealthAmerica argues that Pilot Life forecloses debate and that Menton's claim is pre-empted by ERISA as one "relating to" an employee benefit plan. We disagree. Pilot Life involved an individual who was receiving benefits under a plan insured by the Pilot Life Insurance Company. In 1975, Everate W. Dedeaux injured his back in an accident related to his employment with Entex, Inc. Entex sponsored a long-term disability plan that qualified as an

employee benefit plan under ERISA, for employees who became permanently disabled. While Entex assumed responsibility for the disability plan's day-to-day operation and administration, benefits under the plan were provided by a group insurance policy issued by Pilot Life Insurance Company.

Following Dedeaux's accident, Pilot Life provided benefits to him for two years. His benefits under the plan were first interrupted, then terminated altogether. When they were discontinued, Dedeaux sued Pilot Life. Although the complaint in Pilot Life contained a count for "fraud in the inducement," the opinion makes it unmistakably clear that the only claims he pursued were claims seeking damages for improperly processing his claims for benefits under an ERISA-regulated plan. Justice O'Connor, writing for the Supreme

Court, stated as follows:

> "Although Dedeaux's complaint pled several state common law causes of action, before this Court Dedeaux has described only one of the three counts--called 'tortious breach of contract' in the complaint, and 'the Mississippi law of bad faith' in respondent's brief--as protected from the pre-emptive effect of Section 514(a). The Mississippi law of bad faith, Dedeaux argues, is a law 'which regulates insurance,' and thus is saved from pre-emption by Section 514(b)(2)(A)."

Pilot Life Ins. Co. v. Dedeaux, 481 U.S. at 48, 107 S.Ct. 1549, 1553, 95 L.Ed.2d 39, at 48 (foot-note omitted). Having considered this single count, the Court held:

> "[W]e conclude that Dedeaux's state law suit asserting improper processing of a claim for benefits under an ERISA-regulated plan is not saved by Section 514(b)(2)(A), and therefore is pre-empted by Section 514(a)."

Id. 481 U.S. 41, at 57, 107 S.Ct. 1549 at 1558, 95 L.Ed.2d 39, at 54 (footnote omitted).

Pilot Life merely cleared the confusion

that Metropolitan Life had created in the lower federal courts. Following Metropolitan Life, several lower courts held that insurance companies serving as claims review fiduciaries to fully insured employee benefit plans were subject to the full measure of state remedies, while fiduciaries of self-insured plans were not. Pilot Life rejected the artificial distinction between fully-insured and self-insured plans created by Metropolitan Life.

In this case, Menton does not claim improper processing of a claim, nor any benefits under the terms of the plan. To the contrary, he claims he was fraudulently induced to drop his existing coverage by misrepresentations made by the defendants to him prior to his becoming a member of the HealthAmerica plan. This is the clear

distinction between this case and Pilot Life.

The Supreme Court has not drawn a hard, clear line as to which state law is pre-empted by Section 514(a). This is demonstrated by the case of Ft. Halifax Packing Co. v. Coyne, 482 U.S. 1, 107 S.Ct. 2211, 96 L.Ed.2d 1 (1987), which was decided two months after Pilot Life. In Ft. Halifax, the Court held that a Maine statute requiring employers to make a one-time severance payment to employees when a plant closed was not preempted by ERISA. The Court noted that the preemption clause expressly states that state laws are superseded to the extent that they "relate to any employee benefit plan." The Court stated that the preemption provision "does not refer to state laws relating to 'employee benefits,' but to state laws relating to

'employee benefits plans.'" Id., at 7. (Emphasis in original.) The Court observed that ERISA uses the words "benefit" and "plan" separately throughout and nowhere treats the two as synonymous. "Given the basic difference between a 'benefit' and a 'plan,' Congress' choice of language is significant in its pre-emption of only the latter." Id. at 8, 107 S.Ct. at 2216, 96 L.Ed.2d at 9 (1987).

The distinction made by the Court in Ft. Halifax, between laws that relate to employee benefits plans and laws that relate simply to employee benefits is analogous to the instant case and demonstrates why Menton's claim for fraudulent inducement does not "relate to" HealthAmerica's plan.

Teper v. Park West Galleries, Inc., 431 Mich. 202, 427 N.W. 2d 535 (1988), presented a much closer question on preemption than

exists here. In that case the Michigan Supreme Court held that a plaintiff's claim against her employer for breach of an employment contract, which claimed, in part, compensation for future pension benefits, was not preempted by ERISA. The court held that "the simple fact that the damage award was based in part upon the terms of the plan does not place any fiscal or administrative burden upon the plan itself. This relationship to the plan is, in the words of the Shaw Court, too 'peripheral' to trigger ERISA preemption." 431 Mich. at 208, 427 N.W.2d at 541. Chief Justice Riley, concurring with the majority in Teper, found ERISA's definition of a "state" important for the purposes of the ERISA preemption clause:

> "Congress has further explained the scope of ERISA preemption in the definitional section, 29 U.S.C. Section 1144(c)(2), wherein the

> term 'state' for preemption purposes is characterized as 'a State, any political subdivision thereof, or any agency or instrumentality of either, which purports to regulate, directly or indirectly, the terms and conditions of employee benefit plans covered by this subchapter."

431 Mich. at 212, 427 N.W.2d at 545 (emphasis in original).

In Quigley v. UNUM Life Ins. Co., 688 F.Supp. 80 (D.Mass.1988), the plaintiff's decedent was a participant in a retirement pension plan. Plaintiff's decedent received eight years' of monthly annuity payments following his retirement. Following his death, his estate brought an action against UNUM for breach of contract and misrepresentation. UNUM contended that the claims were preempted by ERISA. The federal district court rejected UNUM's preemption argument, finding that the plaintiff's causes of action were "so tenuously related to an ERISA plan that the claims are not preempted." Id., at 82. In so holding the

court found:

> "The dispute in this case does not involve the plan and the plaintiffs do not claim that any term of the pension plan was violated...Litigation of these issues will not, in effect, result in state regulation of the pension plans contrary to the purposes of ERISA. The concern which motivated the enactment of the ERISA preemption provisions, the threat of inconsistent and conflicting state regulations of ERISA plans, is not implicated if this action is allowed to go forward. See, Ft. Halifax Packing Co. Inc., v. Coyne, 482 U.S. 1, 107 S.Ct. 2211, 2216, 96 L.Ed.2d 1 (1987)."

Id., at 82-83.

In Greenblatt v. Budd Co., 666 F.Supp. 735 (E.D.Pa.1987), the plaintiff sued his employer for misrepresenting to him that the benefits he was receiving under one of the two pension plans would be made equal to those available under the other plan. The Court, after first acknowledging that the Supreme Court has determined that "Congress

made the preemption provision 'deliberately expansive' and 'designed to "establish pension plan regulation exclusively as a federal concern,"'" id., at 741, quoting Pilot Life, rejected the employer's argument that ERISA pre-empted the plaintiff's claim:

> "The cause of action for misrepresentation alleged by the plaintiff at Count II of his complaint should not be preempted because, simply put, the premise underlying this action was that plaintiff was deceived by the verbal statements made and the actions taken by his employer. That the subject of the deception concerned pension benefits is only incidental and not essential to the plaintiff's cause of action. Like promises for a raise in salary, a promotion, or the use of tickets to a baseball game, plaintiff's employer's promise to provide the plaintiff with certain benefits at some unknown time in the future, upon which the plaintiff could reasonably rely, is the essence of the fraud alleged."

Id., at 742. In accord: Morningstar v. Meijer, Inc., 662 F.Supp. 555 (E.D.Mich. 1987) (plaintiff's claim for breach of employment contract against former employer did not "relate to" ERISA plan, despite the

fact that plaintiff claimed as part of her damages the value of certain future fringe benefits under an ERISA plan); McNaee v. Bethlehem Steel Corp., 692 F. Supp. 1477 (E.D.N.Y.1988) (plaintiff claimed fraudulent misrepresentation by employer that upon rehiring he would suffer no break in pension coverage, and court found that because plaintiff's claim did not "seek benefits under the plan" his claim was not pre-empted).

Courts nationwide continue to struggle with ERISA preemption issues occasioned by the "relate to" language in Section 514(a). See: Springer v. Wal-Mart Assoc. Group Health Plan, [No. 88-AR-5226, June 6, 1989] _____F.Supp._____ (N.D.Ala. 1989); Amos v. Blue Cross-Blue Shield of Alabama, 681 F.Supp. 1515 (N.D.Ala.1988), rev'd, 868 F.2d 430 (11thCir.1989); Farlow v. Union Central

Life Ins. Co., 874 F.2d 791 (11thCir.1989); Anschultz v. Connecticut General Life Ins. Co., 850 F.2d 1467 (11thCir. 1988); Belasco v. W.K.P. Wilson & Sons, Inc., 833 F.2d 277 (11thCir.1987); Jordan v. Reliable Life Ins. Co., 694 F.Supp. 822 (N.D. Ala.1988); Graves v. Blue Cross of California, 688 F.Supp. 1405 (N.D.Cal.1988); Mackey v. Lanier Collections Agency & Service, Inc., 486 U.S. ___, 108 S.Ct. 2182, 100 L.Ed.2d 836 (1988); Board of Trustees of Cedar Rapids Pediatric Clinic, P.A., Pension Plan v. Continental Assurance Co., 690 F.Supp. 792 (W.D.Ark.1988); Perry v. P*I*E Nationwide, Inc., 872 F.2d 157 (6thCir. 1989); Idaho Plumbers and Pipefitters Health and Welfare Fund v. United Mechanical Contractors, Inc., 875 F.2d 212 (9thCir.1989); Totton v. New York Life Ins. Co., 685 F.Supp. 27 (D.Conn.1987); Tesch v. General

Motors Corp., 685 F.Supp. 1084 (E.D.Wis. 1988); Southern California Meat Cutters Unions & Food Employers Pension Trust Fund v. Investors Research Co., 687 F.Supp. 506 (C.D.Cal.1988); Hall v. Pennwalt Group Comprehensive Medical Expense Benefits Plan, (E.D.Pa.1989); Schultz v. Boesken Elec. Co., 703 F.Supp. 6565 (S.D.Ohio 1988); Urban Health Services, Ltd. v. Travelers Ins. Co., 703 F.Supp. 53 (N.D.Ill.1989); Holmes v. Pacific Mut. Life Ins. Co., 706 F.Supp. 733 (C.D.Cal.1989); Seafarers' Welfare Plan v. Dixon, 512 So.2d 53 (Ala.1987); Davidian v. Southern California Meat Cutters Union & Food Employees Benefit Fund, 859 F.2d 134 (9thCir.1988); Hood v. Prudential Ins. Co. of America, 522 So.2d 265 (Al.1988); Landy v. Travelers Ins. Co., 530 So.2d 214 (Ala.1988); Massachusetts v. Morash, 490 U.S. _____, 109 S.Ct. 1668, 104 L.Ed.2d 98,

(Mass. 1989). Although there is authority on both sides, the better reasoned cases, and those which recognize the dual role of state and federal law after ERISA, have reached the conclusion that we have reached today.

Authors Kilberg and Inman in their Observation, Preemption of State Laws Relating to Employee Benefit Plans: An Analysis of ERISA Section 514, 62 Tex.L.Rev. at 1328-30 (1984), suggest that the Act contemplates a different approach to these cases. They argue, and we agree, that the Act itself provides a better formula for discerning which state cases are preempted and which are not:

> "Although the courts often have turned to the 'indirectly' language of section 514(c)(2) in their analysis, they have largely ignored another critical word contained in the same clause. Section 514(c)(2) defines a 'State' as an entity that '

purports to regulate, directly or indirectly, the terms and conditions' of the plan.

"An inquiry into the significance of the word 'purports' sheds considerable light on the elusive 'relate to' language of section 514(a). 'Purport' has two ordinary meanings: 'to...imply or profess outwardly' and 'to have in mind.' Both meanings comprehend purpose--the first speaks to apparent purpose, the second to actual purpose or intent. In the state law context, an apparent purpose to regulate, manifested by a reference to employee benefit plans in the text of the law, invariably reflects an actual regulatory purpose. Hence, any law expressly directed toward employee benefit plans 'purports' to regulate the plans within the meaning of section 514.

"Congress meant to preempt such state laws, however, whether or not they are styled as employee benefit plan regulations. In light of this congressional intent, 'purports' must be construed in its 'normal sense' of 'to have in mind.' This construction necessitates an inquiry into the actual legislative or judicial purpose underlying the state law in question. To determine whether the purpose of a state

law is to regulate benefit plans, a court should identify what the law seeks to accomplish and ask whether the law presupposes the existence of benefit plans to achieve that aim. If the purpose of the law is to affect the terms and conditions of employee benefit plans, the law may be found to 'relate to' the plans under section 514(a). If such a purpose is absent, the 'relate to' requirement will not be met and the law will not be preempted, even though it may have some tangible effect on benefit plans.

"This purpose-effect distinction serves well to identify those state 'legislative' laws that Congress intended to preempt with section 514. In addition, this approach is useful in determining whether section 514 preempts a state court or agency application of an otherwise valid state law to a benefit plan. In these adjudicative settings, a second "State Law' emerges that seeks to impose a provision of state law on the plan irrespective of the plan's terms. Such state adjudications invariably 'purport' to regulate the plan and consequently should be preempted under section 514(a). State adjudicative decisions raise a different issue, however, when the decisions are grounded in the terms of the plan itself, rather than in the terms of the state law

applied to the benefit plan. The question then arises whether this act of interepresentation itself constitutes a state law that 'relates to' the plan. This problem is treated in the following subpart.

"Section 502(a)(1)(B) provides that a participant or beneficiary of a plan may bring a civil action 'to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan...' Section 503(e)(1) provides that this civil action may be brought in either federal or state court. To reconcile this grant of concurrent jurisidiction with section 514's pre-emption of state laws that regulate the terms and conditions of a plan, state court decisions that merely interpret the terms of the plan in order to adjudicate the rights of a participant or beneficiary must be deemed not to regulate the plan's terms and conditions. Any other conclusion would reduce the grant of concurrent jurisdiction to surplusage: decisions sanctioned by sections 502(a)(1)(B) and 502(e)(1) would be preempted by section 514.

"Thus, the jurisdictional sections of ERISA, by allocating authority to the state courts to interpret the terms of a plan, imply that

> interpretation alone does not constitute regulation of the terms and conditions of a plan. If interpretation is not regulation of the plan's terms when federal and state courts have concurrent jurisdiction, there is no basis for a different conclusion when the state court interprets the terms of a plan in a case over which only the state court has jurisdiction. Thus, although the states are barred from regulating employee benefit plans, they are invited to construe the plans' terms, a task that often entails construing ERISA's requirements. The states can, therefore, create decisional law, but they may not apply existing state law, decisional or otherwise, that overrides the terms of the plan."

Neither Alabama's fraud statute nor the common law action for fraud purports to regulate, directly or indirectly, the terms and conditions of a plan, and the application of Alabama's fraud law to the facts of this case does not relate to or affect the administration of the plan.

The analysis suggested by Kilberg and Inman would promote the policy endorsed by the United States Supreme Court in Ft.

Halifax: "ERISA pre-emption analysis 'must be guided by respect for the separate spheres of government authority preserved in our federalist system.'" 482 U.S. at _____, quoting Alessi v. Raybestos-Manhattan, Inc., supra. It is equally consistent with the Court's decision in Metropolitan Life Insurance Co. v. Massachusetts, where the Court stated: "We must also presume that Congress did not intend to preempt areas of traditional state regulation." 471 U.S. at 724, 105 S.Ct. 2380, 85 L.Ed.2d 728 (1985).

The defendants argue that the trial court erred in allowing Menton to amend his complaint after final judgment was entered, to allege a violation of the "twisting" statute, Section 27-12-6. The trial court did not err, for two reasons. The first is that every element underlying the "twisting" statute is included in the plaintiff's

complaint stating a common law cause of action for fraud, now codified at Section 6-5-101 (misrepresentations of a material fact made willfully to deceive, or recklessly without knowledge). Therefore, the amendment to the complaint alleging violation of Section 27-12-6 was redundant,, and it could not have prejudiced the defendants in any way. Second, if it is assumed for purposes of argument, or if some other court decides that a claim under Section 6-5-101 or its common law counterpart is preempted by section 514(a) of ERISA, then we would hold that a claim under section 27-16-6 could still be maintained under the saving clause of ERISA as a state law regulating the business of insurance:

> "[N]othing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance..."

Section 514(b)(2)(B), 29 U.S.C. Section 1144(b)(2)(A).

The purpose of Chapter 12 ("Trade Practices Law") of Title 27 ("Insurance") of the Alabama Code is expressed in Section 27-12-1(a):

> "The purpose of this chapter is to regulate trade practices in the business of insurance in accordance with the intent of congress as expressed in the Insurance Regulation Act by defining, or providing for the determination of, all such practices in this state which constitute unfair methods of competition or unfair or deceptive acts or practices and by prohibiting the trade practices so defined or determined." (Emphasis added.)

Section 27-12-6 ("Twisting") provides as follows:

> "No person shall make or issue, or cause to be made or issued, any written or oral statement misrepresenting or making misleading incomplete comparisons as to the terms, conditions, or benefits contained in any policy for the purpose of inducing, or attempting or tending to induce, the policyholder to lapse, forfeit, surrender, retain, exchange or convert any insurance policy."

Section 27-1-2(3) defines "person" for the purposes of Title 27 as follows:

> "An individual, insurer, company, association, organization, Lloyd's insurer, society, reciprocal insurer or interinsurance exchange, partnership, syndicate, business trust, corporation and every legal entity."

The United States Supreme Court in Pilot Life looked to "common sense" and to the McCarran-Ferguson Act, 15 U.S.C. Section 1011 et seq., in interpreting the saving clause, and in doing so it used the following criteria to determine whether a practice falls under the "business of insurance":

> "'[F]irst, whether the practice has the effect of transferring or spreading a policyholder's risk; second, whether the practice is an integral part of the policy relationship between the insurer and the insured; and third, whether the practice is limitd to entities within the insurance industry."

Pilot Life, 481 U.S. at 48, 107 S.Ct. at 1553-54, 95 L.Ed.2d at 48 (1987) (quoting Union Labor Life Ins. Co. v. Pireno, 458

U.W. 119, 129 (1982)). The legislature of Alabama, in adopting the "twisting" statute Section 27-16-6, has enacted a fraud and misrepresentation statute that specifically relates to the insurance industry and, therefore, we believe it is "saved" from preemption by a proper interpretation of Section 514(b).

We acknowledge that the Eleventh Circuit Court of Appeals has held in Farlow v. Union Cen. Life Ins. Co., [No. 88-7513, Jun 6, 1989] ___F.2d ___ (1989), that the Alabama "twisting" statute does not create a private cause of action and that, if it did, a claim under it would be pre-empted under ERISA if the employer's conduct giving rise to the claim was not "wholly remote in content" from the benefit plan. Presumably, under this holding, the commissioner of insurance would be preempted from imposing

the statutory sanctions against insurance companies that violate Section 27-12-1 et seq. We are unconvinced that Congress intended this result.

We recognize that the cases from the various federal courts are disparate. We adopt the position taken by the Sixth Circuit on the precise issue involved in this case: fraud in the inducement. Perry v. P*I*E Nationwide, Inc., 872 F.2d 157 (6thCir.1989). In that case, the plaintiffs alleged that the defendant had fraudulently induced them to participate in a plan covered by ERISA. The defendants claimed pre-emption under section 514(a). The district court held that "preemption by ERISA applies only once the benefit plan is in existence" and does not apply to alleged common law actions of fraud or misrepresentation "to get the plaintiffs to join the

plan." Because the purported misconduct of P*I*E occured before the plaintiffs became participants or beneficiaries, and because they were not suing for benefits under the plan, the district court had held that preemption did not apply. In accord, Butler v. Fringe Benefits Plan, Inc., 701 F.Supp. 804 (N.D.Ala.1988).

The Circuit Court of Appeals for the Sixth Circuit affirmed, citing Miller v. Lay Trucking Co., 606 F.Supp. 1326 (N.D.Ind. 1985) (holding that the plaintiff's common law action for fraudulent inducement was not preempted by ERISA because the fraud occurred prior to the time the plaintiff entered the plan, and because the fraud claim did not directly affect the regulation of the ERISA plan).

The Sixth Circuit acknowledged, as we do that there is respectable authority for

the positions taken by both sides concerning pre-emption of state common law claims of fraud, etc. It adopted in Perry the position expressed in Dependahl v. Falstaff Brewing Corp., 653 F.2d 1208 (8thCir.), cert. denied, 454 U.S. 968, 102 S.Ct. 512, 70 L.Ed.2d 384 (1981), that preemption should apply to a state law claim only if Congress has provided a remedy for the wrong or wrongs asserted.

Congress has not provided a remedy for the wrong asserted by Mr. Menton, and we are loath to imply an intent on its part to do so.

We next address the defendants' contention that the trial court erred in deny-

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Cefalu v. B.F. Goodrich Co., 871 F.2d 1290 (5thCir.1989); Cantrell v. Great Republic Ins. Co., 873 F.2d 1249 (9thCir.1989); Straub v. Western Union Telegraph Co., 851 F.2d 1262 (10thCir.1988); Hermann Hosp. v. Meba Medical & Benefits Plan, 845 F.2d 1286 (5th Cir.1988).

ing the defendants' motion for a mistrial based upon alleged improper argument by plaintiff's counsel. The defendants claim that the plaintiff's counsel improperly aroused the passion and prejudice of the jury against the defendants. The plaintiff claims that the jury verdict is the result of the overwhelming evidence of fraud, cover-up, and conspicuously selective memories that was introduced at the trial of the case. We have repeatedly held that in fraud actions "great latitude is allowed in the scope of evidence introduced." Simmons Mach. Co. v. M & M Brokerage, Inc., 409 So.2d 743, 756 (Ala.1981). The reason for allowing such latitude is that the perpetrator of a fraud is often the sole possessor of the actual knowledge of fraud. Sessions Co. v. Turner, 493 So.2d 1387, 1391 (Ala.1986).

Questions of materiality, relevancy,

and remoteness of evidence are matters resting within the discretion of the trial court, whose exercise of that discretion will not be reversed unless it has been grossly abused. Dorcal, Inc. v. Xerox Corp., 398 So.2d 665, 670-71 (Ala.1981). This discretion extends to argument of counsel. We have said:

> "The control of arguments rests largely in the discretion of the trial court, before whom the argument is made, and who sees and can judge the demeanor of the counsel making the argument, and who can determine whether a prejudicial atmosphere is created by such remarks; therefore, we will not interfere where this discretion is not abused."

Southern Ry. Co. v. Javris, 266 Ala. 440 at 446, 97 So.2d 549 (1957), in accord, Old Southern Life Ins. Co. v. Woodall, 348 So.2d 1377 (Ala. 1977).

Counsel may state or comment upon all evidence admitted at trial and draw infer-

ences and conclusions from that evidence. Seaboard Coastline R.R. v. Moore, 479 So .2d 1131 (Ala.1985). This Court has established a standard of review on claims for improper argument whereby we will not reverse unless substantial prejudice has resulted. Id., at 1136. In denying defendants' motion for a JNOV, new trial, and remittitur, the trial court stated: "[T]he court cannot call to mind [nor] have the attorneys for the defendants shown to the court any factor at all that could be construed to indicate bias, passion, prejudice, corruption, or other improper motive or cause on the part of the jury."

We recently affirmed a trial court's refusal to grant a mistrial, under circumstances similar to the present case, in which there was a reference to the wealth of the defendants. We observed that the court

heard the remark in context, witnessed the effect upon the jury, and was able to make a better judgment that we were as to whether the remark was improper argument and might have prejudiced the jury. L.W. Johnson & Assoc., Inc. v. Rivers Construction Co., 532 So .2d 618 at 625 (Ala.1988). We have carefully examined the record in this case and find no error by the trial judge, who had the opportunity to judge the demeanor of counsel and who could determine whether his remarks created a prejudicial atmosphere.

The defendants also claim that the trial court erred in charging the jury. The jury asked: "Are the defendants 'the corp. and Pam' or 'the corp. or Pam?'" The judge replied:

> "THE COURT: Well, for your purposes it doesn't make any difference. I mean the corporation is fully responsible for the acts of its agents, so it

> doesn't make any difference. I mean, you know, we're concerned--you know, the representations are the representations of the agent. I mean, I don't think I--is that--
>
> "JUROR: That's what we needed to know."

Defendants admit that the trial court correctly instructed the jury that a corporation is responsible for the acts of its agent. We find no error in so instructing the jury.

Defendants contend that the trial court erred in refusing to submit special verdict questions to the jury and in charging the jury as to reckless fraud. Under Rule 49, Ala. R. Civ. P., the use of a special verdict is within the sound discretion of the trial court. After instructing the jury on willful misrepresentation, based on the Alabama Pattern Jury Instructions, the trial court charged the jury on the definition of reckless misrepresentation as follows:

> "A reckless misrepresentation which is also actionable [sic]; the law says that if you are reasonably satisifed from the evidence that the defendant misrepresented a material fact recklessly without knowledge of the truth or falsity thereof and with the intent to induce the plaintiff to act and that the plaintiff acted upon said reckless misrepresentation to his injury, then the defendant is also guilty of a legal fraud under those circumstances.
>
> "If the plaintiff has not proved the case of fraud through either an intentional or a reckless misrepresentation as I just described to you, you would go no further. Your verdict would be for the defendant." [R. 295-96.]

One of the Alabama pattern jury instructions defines "reckless misrepresentation" as follows:

> "If you are reasonably satisfied from the evidence that the defendant misrepresented a material fact recklessly without knowledge of the truth or falsity thereof and with the intent to induce plaintiff to act and and that plaintiff acted upon said reckless misrepresentation to his injury, then defendant is guilty of a legal fraud."

Alabama Pattern Jury Instructions (Civil), Instruction 18.02, p. 270.

During jury deliberations, the jury had a question. The trial court asked the foreman: "You want me to define a reckless misrepresentation?" The foreman replied: "Yes, Sir." To this the trial judge responded:

> "If you are reasonably satisfied from the evidence that the defendants misrepresented a material fact recklessly without knowledge of the truth or falsity and with the intent to induce the plaintiff to act, and the plaintiff did act upon the reckless misrepresentation to his injury, then the defendant is guilty of a legal fraud." [R. 306]

The trial court gave the identical definition of reckless misrepresentation both during his oral charge and after the jury's question. In doing so, he correctly charged the jury.

The defendants also contend that the court's charge on punitive damages in a

fraud case constitutes reversible error. The longstanding rule of this Court is as follows:

> "[P]unitive damages may be recovered in a fraud action if the fraudulent misrepresentation was malicious, oppressive, or gross, or made with knowledge of its falsity or so recklessly as to amount to the same thing or was made with the purpose of injuring the plaintiff."

Curry Motor Co. v. Hasty, 505 So.2d 347 (Ala. 1987). See: Morgan v. South Central Bell Telephone Co., 466 So.2d 107 (Ala. 1985).

In the present case, the trial judge instructed the jury in his oral charge as follows:

> "[T]he law says that you are authorized to award punitive damages in a fraud action if it is shown to your reasonable satisfaction from the evidence that the fraud was malicious, oppressive, or gross, or a misrepresentation was made with the knowledge of its falseness or so recklessly done as to amount to the same thing and

committed with the intent to injure and to defraud." [R. 296-97.]

The jury had a question on the meaning of reckless fraud during its deliberations. The trial court further instructed the jury as follows:

> "I just want to clarify one thing, ladies and gentlemen, I want to clarify this: the definition I just read you would authorize if the plaintiff proved it, to recover actual damages. With respect to recovering punitive damage, the law says that the fraud must be malicious, oppressive or gross or made with knowledge of the falseness of the representation or so recklessly done as to amount to the same thing and committed with the intent to injure and defraud."

The trial court did not err in charging the jury.

The defendants argue that the trial court erred in denying their motions for directed verdict, judgment notwithstanding the verdict, and a new trial based upon the insufficiency of the evidence of either intentional or reckless fraud. We have

carefully reviewed the record in this case. The record supports the decision of the trial judge.

The defendants argue that the award of punitive damages violates the Constitution of Alabama and the Constitution of the United States of America. They argue that the jury verdict of $1,797,588 in punitive damages is based upon only $2,412 in compensatory damages. However, the defendants did not raise any constitutional question prior to filing their motion for judgment notwithstanding the verdict, or, in the alternative, for a new trial or for a remittitur. Although the trial judge, in his order of June 13, 1988, states that the defendants' challenges to the constitutionality of the award of punitive damages "were timely raised and effectively presented," in fact, these issues were not raised until 29

days after the trial court had entered judgment on the jury's verdict.

It is settled law that constitutional issues must be raised before the trial court in order to be preserved for review upon appeal. Marion v. Hall, 429 So.2d 937 (Ala.1983); Talley v. A & M Construction Co., 284 Ala. 371, 373, 255 So.2d 359, 360 (1969), cert. denied, 397 U.S. 995, 90 S.Ct. 1133, 25 L.Ed.2d 402 (1970); Hicks v. Huggins, 405 So.2d 1324 (Ala.Civ.App.), cert. denied, 405 So.2d 1328 (Ala. 1981). We have declined previously to consider similar issues because "these challenges were not presented for resolution before the trial court and [were] presented for the first time on appeal." Nationwide Mutual Ins. Co. v. Clay 525 So.2d 1339, 1344 (Ala.1987), cert. denied, ___U.S.___, 109 S.Ct. 863, 102 L.Ed.2d 988 (1989). Thus,

the defendants did not preserve their constitutional issues for appeal. However, we would be remiss if we neglected to note that the United States Supreme Court has recently ruled in the case of Browning-Ferris Industries of Vermont, Inc. v. Kelco Disposal, Inc. [No. 88-556, June 26, 1989) ___U.S.___ (1989) that the excessive fines clause of the Eighth Amendment does not apply to punitive damages awards in cases between private parties. In doing so, the Supreme Court upheld an award of $6 million in punitive damages when the compensatory damages were $511,146.

Finally, the defendants claim that the verdict of the trial court was excessive and should be set aside.

With respect to the question of a remittitur, it is within the authority of this Court to order a remittitur, pursuant

to Code of Alabama (1975), Section 12-33-71, if it finds the judgment to be excessive. The rules that govern this Court's review of a verdict claimed to be excessive were set out in Vest v. Gay, 275 Ala. 286, 154 So.2d 297 (1963):

> "'The rules governing our consideration of this question are clear and have be reiterated quite often. We refer to them briefly for emphasis: The verdict of a jury should not be interfered with merely because in the opinion of the court the jury gave too little or too much...; and the authority vested in the courts to disturb a verdict of the jury on the ground of excessive damages is one which should be exercised with great caution...; where there is no set standard for the admeasurement of the damages but the damages to be awarded are left to the sound discretion of the jury, a remittitur or a new trial should not be ordered on the ground of excessiveness of the jury's verdict except in those cases where the court can clearly see that the verdict has been reached on account of bias, passion, prejudice, corruption, or other improper motive or cause...; but

> where the damages allowed are so excessive as to warrant the belief that the jury must have been misled by some mistaken view of the merits of the case the court may interfere and set the verdict aside...; also, where the trial court refuses to grant a new trial because [it] does not believe the verdict to be excessive, the favorable presumption attending the jury's verdict is thereby strengthened...'"

(As quoted in Black Belt Wood Co., Inc. v. Sessions, 514 So.2d 1249, at 1264-65 (Ala. 1986).)

The trial court issued an order denying defendant's motion for a remittitur, and in it the trial judge expressly acknowledged that he had carefully considered all of the evidence on all issues. The trial judge noted that a remittitur or new trial is proper "where the court can clearly see that the verdict is tainted by bias, passion, prejudice, corruption, or other improper motive or cause on the part of the jury."

The trial court stated in his order as follows:

> "The Court has carefully considered all of the evidence in the case on all issues. The Court has carefully considered the nature and quality of the testimony of all of the witnesses, as well as the demeanor of each witness while testifying. The Court has further reviewed its Charge to the jury on the issue of damages and has found that it correctly instructed the jury on damages. As a part of the charge, the jury was instructed that if they found in favor of the Plaintiff, Edward Menton, and against the Defendants, HealthAmerica and Pamela Merle, that in assessing damages they should take into consideration and give due regard to the enormity of the wrong and the necessity of preventing similar wrongs in the future.
>
> "After a careful review by the Court of the entire trial of the case, including the testimony of all of the witnesses, all of the documentary and demonstrative evidence produced at trial, the Court's observation of all parties and witnesses, and the Court's charge to the jury on damages, the Court is convinced that the jury carefully and conscientiously followed the Court's instructions in assessing damages in the case at $1,800,000.00 and that the award is

consistent with the Court's instructions and supported by the evidence.

"The Court finds, after a review of the entire trial, that the central issue presented in the Defendants' motion for remittitur is whether or not the jury verdict of $1,800,000.00 in this case is, in and of itself, evidence of bias, passion, prejudice, corruption or other improper motive or cause. The Court cannot call to mind [nor] have the attorneys for the Defendants shown to the Court any factor at all that could be construed to indicate bias, passion, prejudice, corruption, or other improper motive or cause on the part of the jury. On the contrary, the Court finds that there was clear and convincing evidence of fraud on the part of the Defendants, HealthAmerica and Pamela Merle, which in the Court's opinion fully justified the jury's verdict.

"The Court finds that the $1,800,000.00 verdict is not excessive and is not the result of bias, passion, prejudice, corruption, or other improper motive or cause."

We have reviewed this order of the trial judge, and we find that he followed the guidelines we have previously adopted to be used by a trial court in reviewing judg-

ments. Hammond v. City of Gadsden, 493 So.2d 1374 (Ala.1986); Harmon v. Motors Ins. Corp., 493 So.2d 1370 (Ala. 1986); Alabama Farm Bureau Mutual Cas. Ins. Co. v. Griffin, 493 So.2d 1379 (Ala.1986). The trial judge applied the principles of law adopted in those cases, held a hearing, and set forth the reasons why he felt that the law did not authorize him to order a remittitur.

We have examined the record in the light of our rules as to remittitur. We are of the opinion that the judgment of the trial court, including the damages award, which the trial court reviewed on motion for JNOV, for a new trial, and for remittitur, is due to be, and is hereby is, affirmed.

AFFIRMED.

Hornsby, C. J., and Jones, Adams, Steagall, and Kennedy, JJ., concur.

Maddox and Houston, JJ., dissent, with opinion by Houston, J.

HOUSTON, JUSTICE (dissenting) The second paragraph in Article VI, of the Constitution of the United States, provides:

> "This Constitution, and the laws of the United States which shall be made in pursuance thereof; and all treaties made, or which shall be made, under the authority of the United States, shall be the supreme law of the land; and the judges in every state shall be bound thereby, any thing in the Constitution or laws of any state to the contrary notwithstanding." (Emphasis supplied.)

If I were writing on a clean slate, freed from the deference that I do and must give to the opinions of the United States Supreme Court, I could reach the result reached by the majority of this Court in this case, on the preemption issue, for I would adopt the "purpose-effect" and "regulation-interpretation" distinctions

suggested as an alternative approach to the "relate to" requirement by William J. Kilberg's and Paul D. Inman's article Preemption of State Laws Relating to Employee Benefit Plans: An Analysis of ERISA Section 514, 62 Tex.L.Rev. 1313, 1328-30 (1984). However, I have given my solemn oath to uphold the Constitution of the United States, and that includes the second paragraph of Article VI; therefore, I must dissent.

Justice O'Connor, in delivering the opinion for a unanimous Court in Pilot Life Insurance Co. v. Dedeaux, 481 U.S. 41, 44-46, 107 S.Ct. 1549, 1551-52 (1987), wrote:

> "In ERISA, Congress set out to
>
> "'protect...participants in employee benefit plans and their beneficiaries, by requiring the disclosure and reporting to participants and beneficiaries of

> financial and other information with respect thereto, by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts.' Section 2, as set forth in 29 U.S.C. Section 1001(b).

"ERISA comprehensively regulates, among other things, employee welfare benefit plans that, 'through the purchase of insurance or otherwise,' provide medical, surgical, or hospital care, or benefits in the event of sickness, accident, disability or death. Section 3(1), 29 U.S.C. Section 1002(1).

"Congress capped off the massive undertaking of ERISA with three provisions relating to the pre-emptive effect of the federal legislation:

> "'Except as provided in subsection (b) of this section [the saving clause], the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan...' Section 514(a), as set-forth in 29 U.S.C. Section 1144(a) (pre-emption clause).
>
> "'....'

"....

"'[T]he question whether a certain state action is pre-empted by federal law is one of congressional intent. "'The purpose of Congress is the ultimate touchstone.'"' Allis-Chalmers Corp. v. Leuck, 471 U.S. 202, 208, 105 S.Ct. 1904, 1909, 85 L.Ed.2d 206 (1985), quoting Malone v. White Motor Corp., 435 U.S. 497, 504, 98 S.Ct. 1185, 1189, 55 L.Ed.2d 443 (1978), quoting Retail Clerks v. Schermerhorn, 375 U.S. 96, 103, 84 S.Ct. 291, 222, 11 L.Ed.2d 179 (1963). We have observed in the past that the express pre-emption provisions of ERISA are deliberately expansive, and designed to 'establish pension plan regulation as exclusively a federal concern.' Alessi v. Raybestos-Manhattan, Inc., 451 U.S. 504, 523, 101 S.Ct. 1895, 1906, 68 L.Ed.2d 402 (1981). As we explained in Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 98, 103 S.Ct. 2890, 2900, 77 L.Ed.2d 490 (1983):

> "'The bill that became ERISA originally contained a limited pre-emption clause, applicable only to state laws relating to the specific subjects covered by ERISA. The Conference Committee rejected those provisions in favor of the present language, and indicated that section's pre-emptive scope was as broad as its language. See H.R.Conf.Rep. No. 93-1280, p. 383 (1974); S.Conf.Rep. No. 93-1090, p. 383 (1974).'"

(Emphasis supplied.)

In Kilberg and Inman's Preemption of State Laws Relating to Employee Benefit Plans: An Analysis of ERISA Section 514, 62 Tex.L.Rev. 1313, 1315-16, the following appears:

> "Express preemption provisions such as section 514 must be distinguished from the implied preemption that arises from the supersession inherent in antithetical federal and state commands on from the encroachment of state law into a field occupied by comprehensive federal regulation or interests. To strike down a state law in an implied preemption case, the court must find either a specific conflict between federal and state commands or a clash between zones of sovereign interest. The goal of an implicit preemption analysis should be to accommodate the federal interest with the least possible displacement of state law. The goals of an express pre-emption analysis, in contrast, should be to prevent subtle or incremental state encroachment into a field that Congress has chosen expressly to reserve for federal law. Yet, courts have mistakenly applied preemption doctrines fashioned in implied pre-emption cases to section 514 cases, in which the issue is whether the federal law -- by its express terms --

> preempts the state law in question. Once Congress has declared its express intent to preempt or to save a state law, it has largely obviated judicial inquiry into considerations other than those concerning the text of the pre-emption provision." (Emphasis supplied.)

"[A]ny and all State laws insofar as they may now or hereafter relate to any employee benefit plan, "subject to certain exceptions that will be discussed later, is what Congress expressly preempted. 29 U.S.C. Section 1144(a). "The term 'State law' includes all laws, decisions, rules, regulations, or other State action having the effect of law... ." 29 U.S.C. Section 1144(c). Does this preempt a civil action by Menton, who is a "participant" (29 U.S.C. Section 1002(7)) and a "party in interest" (29 U.S.C. Section 1002(14)) for an intentional or reckless misrepresentation, by HealthAmerica, which is a "party in interest" (29 U.S.C. Section 1002(14)) as to

the medical coverage benefits provided by a particular employee benefit plan?

Medical coverage benefits are benefits that "accumulate over a period of time and are payable only upon the occurrence of a contingency outside of the control of [Menton];" therefore, they are "risks that ERISA is intended to address, "Massachusetts v. Morash, _____U.S._____, 109 S.Ct. 1668 (1989). Likewise, the phrase "relate to" has been given its broad common-sense meaning, so that a state law relates to an employee benefit plan "if it has a connection with or reference to such a plan." Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 97, 103 S.Ct. 2890, 77 L.Ed.2d 490 (1983); Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724, 105 S.Ct. 2380, 85 L.Ed.2d 728 (1985); Pilot Life Ins. Co. v. Dedeaux, supra. In this case, the

representation was made by a party in interest as to an employee benefit plan to a party in interest as to that same employee benefit plan concerning medical benefits payable under that employee benefit plan. Clearly, the representation related to the employee benefit plan, as "related to" is defined by the United States Supreme Court.

In Pilot Life Ins. Co. v. Dedeaux, supra, Dedeaux's complaint contained three counts: "'tortious breach of contract'"; "'breach of fiduciary duties'"; and "'fraud in the inducement.'" (Emphasis supplied.) 481 U.S. at 43, 107 S.Ct. at 1551. At the closing of discovery, Pilot Life moved for summary judgment, arguing ERISA preemption. The district court entered summary judgment; the Court of Appeals for the Fifth Circuit reversed; the United States Supreme Court granted certiorari and reversed the Fifth

Circuit and reinstated the summary judgment for Pilot Life. In Belasco v. W.K.P. Wilson & Sons, Inc., 833 F.2d 277 (11thCir. 1987), the Eleventh Circuit Court of Appeals held that Alabama state law claims of bad faith and fraud (which a review of the amended complaint in Belasco shows to be remarkably similar to the fraud alleged in the case at issue) of a plaintiff, who was a "participant" and a "party in interest" as to an employee benefit plan against an insurance company that was a "party in interest" as to that employee benefit plan related to the plan and were pre-empted.

The facts in Davidian v. Southern California Meat Cutters Union & Food Employee Benefits Fund, 859 F.2d 134 (9thCir. 1988), are similar to the facts in the case at issue. Davidian, a "participant" and "party in interest" as to

an employee benefit plan, alleged that he was planning to retire and that the plan gave him a choice of one of three benefit programs. A "party in interest" as to the plan described the third option as paying "approximately 80%" of major medical coverage, like plaintiff's prior coverage, but did not inform the plaintiff that, unlike his prior coverage, reimbursement for major medical expenses under the third option was capped at $20,000.00. The plaintiff enrolled in the third option and subsequently underwent heart surgery. The plan refused to pay plaintiff's medical expenses in excess of $20,000.00. Davidian filed suit against the plan for fraud and deceit. The Ninth Circuit held that Davidian's claims were preempted and addressed Davidian's contention that claims for future benefits, as distinguished from

past benefits, are not preempted, as follows:

> "There is no reason for such a distinction based on the purpose of the preemption provisions of the Act. The potential for conflicting and inconsistent state and local regulation of employee benefit plans is as real whether past or future benefits are involved."

859 F.2d at 135.

This Court held that the bad faith refusal to pay insurance benefits under an employee benefit plan by a party in interest as to an employee benefit plan to a party in interest as to that same employee benefit plan did not relate to the plan and was not preempted by ERISA. Hood v. Prudential Ins. Co. of America, 460 So.2d 1227 (Ala. 1984). After the United States Supreme Court decided Massachusetts Mutual Life Insurance Co. v. Russell,, 473 U.S. 134, 105 S.Ct. 3085, 87 L.Ed.2d 96 (1985), and Pilot Life Ins. Co. v. Dedeaux, supra, we reversed

ourselves and held that Hood's bad faith claim was preempted. Hood v. Prudential Ins. Co. of America, 522 So.2d 265 (Ala. 1988). Having had our judicial flexibility rendered rather rigid by our federalist system, we have ruled in favor of ERISA preemption of common law causes of action. See, Landy v. Travelers Insurance Co., 530 So.2d 214 (Ala.1988); Hood v. Prudential Ins. Co. of America, 522 So.2d 265 (Ala.1988); and Seafarers' Welfare Plan v. Dixon, 512 So.2d 53 (Ala.1987).

Justice O'Connor in Pilot Life, supra, wrote:

> "The Solicitor General, for the United States as amicus curiae, argues that Congress clearly expressed an intent that the civil enforcement provisions of ERISA Section 502(a) be the exclusive vehicle for actions by ERISA-plan participants and beneficiaries asserting improper processing of a claim for benefits, and that varying state causes of action for claims within the scope of Section

502(a) would pose an obstacle to the purposes and objectives of Congress. Brief for United States as Amicus Curiae 18-19. We agree. The conclusion that Section 502(a) was intended to be exclusive is supported, first, by the language and structure of the civil enforcement provisions, and second, by legislative history in which Congress declared that the pre-emptive force of Section 502(a) was modeled on the exclusive remedy pro-vided by Section 301 of the Labor-Management Relations Act (LMRA), 61 Stat. 156, 29 U.S.C. Section 185.

"The civil enforcement scheme of Section 502(a) is one of the essential tools for accomplishing the stated purposes of ERISA. The civil enforcement scheme is sandwiched between two other ERISA provisions relevant to enforcement of ERISA and to the processing of a claim for benefits under an employee benefit plan. Section 501, 29 U.S.C. Section 1131, authorizes criminal penalties for violations of the reporting and disclosure provisions of ERISA. Section 503, 29 U.S.C. Section 1133, requires every employee benefit plan to comply with Department of Labor regulations on giving notice to any participant or beneficiary whose claim for benefits has been denied, and affording a reasonable opportunity for review of the decision denying the claim."

481 U.S. at 52-53, 107 S.Ct. at 1555-1556.

(Emphasis supplied.)

In view of this policy, I cannot see how civil actions for bad faith in processing claims for benefits under ERISA plans are preempted and civil actions for misrepresentations made by a "party in interest" to a "party in interest/participant" concerning the coverage under ERISA plans are not, and, indeed, they have been so preempted in most cases since Pilot Life, supra. See, i.e., Pilot Life (fraud in the inducement); Belasco (misrepresentation of benefits payable under an ERISA plan); Davidian (misrepresentation of benefits payable under an ERISA plan). I have studied all of the cases cited in the majority opinion, in briefs, and at oral argument by the parties, and I do not believe that an analysis of each case would be helpful to the bench or bar. Contrary to

what the majority contends, I believe that the weight of authority of cases decided since Pilot Life, supra, supports my conclusion.

Reluctantly, I would hold Menton's claim to be related to the Press Register's employee benefit plan and preempted by ERISA on authority of Shaw v. Delta Air Lines, supra; Metropolitan Life Ins. Co. v. Massachusetts, supra; Pilot Life Ins. Co. v. Dedeaux, supra; Belasco V. W.K.P. Wilson & Sons, Inc., supra; and Davidian v. Southern California Meat Cutters Union & Food Employees Benefits Fund, supra.

I am not persuaded that civil actions for bad faith or fraud have anything to do with regulation of employee benefit plans or that the purpose for such actions is to affect the terms and conditions of employee benefit plans. However, I believe that this

as been decided otherwise by a higher court; and I cannot justify holding that Menton's cause of action does not "relate to" an employee benefit plan in order to save it from pre-emption, when the causes of action asserted in Pilot Life, supra, for tortious breach of contract and fraud in the inducement and the causes of action asserted in Belasco, supra, for bad faith and fraud were held to "relate to" employee benefit plans and therefore to be preempted. To so hold would be to make a distinction without a difference.

Is Menton's cause of action exempted from preemption under 29 U.S.C. Section 1144(b)(2)(A)? That statute reads:

> "[N]othing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance... ."

The trial court indicated that it was not granting HealthAmerica's and Merle's

motions for directed verdict, because the HMO statutes and the Alabama "twisting" statute were laws regulating insurance and, under the evidence, could be the basis of Menton's cause of action. Prior to the final judgment, Menton's complaint did not mention or purport to be brought under either statute.

The HMO statutes did not become effective until May 29, 1986, almost a year after Menton's cause of action accrued. As a general rule, statutes, except remedial statues, will not be construed to have retroactive effect unless the language of the statute expressly indicates that the Legislature so intended. Jones v. Casey, 445 So.2d 873 (Ala. 1983). There is no expression of legislative intent that the HMO statutes apply to causes of action that accrued prior to the effective date of that

legislation. This Court defined remedial statutes in Street v. City of Anniston, 381 So.2d 26, 29 (Ala. 1980), as "those relating to remedies or modes of procedure, which do not create new rights or take away vested ones." For Menton's cause of action to be saved from preemption by the HMO statutes, the statutes would have to regulate insurance and give him a new private cause of action. A statute creating a new right, a new cause of action, is clearly substantive in nature and would not be given retroactive application in the absence of a provision indicating a contrary legislative intent. I need not address whether the HMO statutes create a private cause of action, for if they do they will not be given retroactive effect. Therefore, I need not discuss whether the Alabama HMO statutes "regulate insurance," for Menton's cause of

action for misrepresentation is not saved from preemption by the HMO statutes.

The purpose of Chapter 12 ("Trade Practices Law") is expressed in Section 27-12-1(a):

> "The purpose of this chapter is to regulate trade practices in the business of insurance in accordance with the intent of congress as expressed in the Insurance Regulation Act by defining, or providing for the determination of, all such practices in this state which constitute unfair methods of competition or unfair or decptive acts or practices and by prohibiting the trade practices so defined or determined."

Section 27-12-6 ("Twisting") provides:

> "No person shall make or issue, or cause to be made or issued, any written or oral statement misrepresenting or making misleading incomplete comparisons as to the terms, conditions or benefits contained in any policy for the purpose of inducing, or attempting or tending to induce, the policyholder to lapse, forfeit, surrender, retain, exchange or convert any insurance policy." (Emphasis supplied).

Section 27-1-2(3) defines "person" for the purposes of Title 27 as follows:

> "An individual, insurer, company, association, organization, Lloyd's insurer, society, reciprocal insurer or interinsurance exchange, partnership, syndicate, business trust, corporation and every legal entity."

Section 27-1-2-(2) defines "insurer" for the purposes of Title 27 as follows:

> "Every person engaged as indemnitor, surety or contractor in the business of entering into contracts of insurance."

In Pilot Life, supra, Dedeaux did not contend that his cause of action for fraud in the inducement was a law that regulated insurance and was thus saved from preemption, so this was not discussed by Justice O'Connor in her opinion. Dedeaux did contend that the cause of action for bad faith did regulate insurance and was saved from preemption by Section 514(b)(2)(A). In regard to this, Justice O'Connor wrote that

the Court first took "what guidance was available from a 'common-sense view' of the language of the saving clause itself." 481 U.S. at 48, 107 S.Ct. 1553 ("any law of any State which regulates insurance"). "Second," she wrote, "we made use of the case law interpreting the phrase 'business of insurance' under the McCarran-Ferguson Act, 15 U.S.C. Section 1011 et seq., in interpreting the saving clause"; and, she noted that in doing so the Court used these criteria:

> "'[F]irst, whether the practice has the effect of transferring or spreading a policyholder's risk; second, whether the practice is an integral part of the policy relationship between the insurer and the insured; and third, whether the practice is limited to entities within the insurance industry."

481 U.S. at 49,, 107 S.Ct. at 1553.

In applying the "common sense view", Justice O'Connor reasoned that the phrase -

"regulates insurance" does not support the argument that the Mississippi law of bad faith falls under the saving clause, since the Mississippi Supreme Court, as early as 1915, had recognized that punitive damages were available in a contract case when "'the act or omission constituting the breach of [any contract, not just an insurance] contract amounts also to the commission of a tort.'"

> "Certainly a common-sense understanding of the phrase 'regulates insurance' does not support the argument that the Mississippi law of bad faith falls under the saving clause. A common-sense view of the word 'regulates' would lead to the conclusion that in order to regulate insurance, a law must not just have an impact on the insurance industry, but be specifically directed toward that industry. Even though th Mississippi Supreme Court has identified its law of bad faith with the insurance industry, the roots of this law are firmly planted in the general principles of Mississippi tort and contract law."

481 U.S. at 50, 107 S.Ct. at 1554.

The Alabama "twisting" statute appears to be directed toward the insurance industry. However, since 1907, the Alabama Legislature has provided a civil action for '"[m]isrepresentations of a material fact made willfully to deceive, or recklessly without knowledge." Section 6-5-101. The Alabama Supreme Court, at lease since 1933, has allowed punitive damages to be recovered in such misrepresentation actions, when the misrepresentations were made by the defendant with the intent to defraud the plaintiff. Cartwright v. Hughes, 226 Ala. 464, 147 So. 399 (1933). So the roots of misrepresentation were firmly planted in the general principles of Alabama tort law, before the Legislature enacted the "twisting" statute in 1971. Until the post-final judgment amendment of his complaint, Menton had pursued his civil action against

HealthAmerica and Merle under this firmly planted general principle of Alabama tort law.

In Pilot Life, supra, the United States Supreme Court found that the factors set out in the McCarran-Ferguson Act did not support Dedeaux's assertion that the Mississippi law of bad faith "regulates insurance," for (1) it did not affect a spreading of policy-holder risk; (2) "[t]he state common law of bad faith is ... no more 'integral' to the insurer-insured relationship than any State's general contract law is integral to a contract made in that State." 481 U.S. at 51, 107 S.Ct. at 1555; and (3) "Mississippi's law of bad faith, even if associated with the insurance industry, has developed from general principles of tort and contract law available in any Mississippi breach of contract

case." 481 U.S. at 51, 107 S.Ct. at 1555. The Court then held "the Mississippi common law of bad faith at most meets one of the three criteria used to identify the 'business of insurance' under the McCarran-Ferguson Act, and used in Metropolitan Life to identify law that 'regulat[e] insurance' under the saving clause."

I do not find that the "twisting" statute affected a spreading of the risks among policyholders; or that the "twisting" statute is more integral to the insurer-insured relationship than Alabama's misrepresentation statute, as developed from general principles of tort law; or that the statute in its definition of "person" and "insurer" is limited to entities in the

insurance business.[2] Therefore, using Justice O'Connor's criteria for deter-

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[2] Alabama Code 1975, Section 27-12-24, provides:

> "No insurer shall, without just cause, refuse to pay or settle claims arising under coverages provided by its policies in this state... ." (Emphasis supplied.)

From the pleadings in Belasco v. W.K.P. Wilson & Son, Inc., supra, we cannot determine whether this Code section, which is contained in Chapter 12 ("Trade Practices Law") of Title 27 ("Insurance") was relied on by Belasco as a law regulating insurance.

> "Plaintiffs argue that the Alabama law of bad faith, which forms the basis of one of their claims, is a 'law ... which regulates insurance,' 29 U.S.C. Section 1144(b)(2)(A), and therefore falls under the saving clause. However, the Alabama law of bad faith appears to us to have the same roots 'in the general principles of ... tort and contract law' as was the case in Dedeaux."

833 F.2d at 281

mining when a state law "regulates insurance" and is therefore saved from ERISA preemption, I would find that the "twisting" statute does not save Menton's claim from preemption. By this, I do not mean to imply that Alabama's "twisting" statute affords a private cause of action to Menton.[3] I need not reach this issue.

A unanimous United States Supreme Court in Pilot Life , supra, held that Dedeaux's state law claims, including bad faith and fraud in the inducement, were preempted, even though Dedeaux elected not to assert any of the remedies that would be available under ERISA. Menton elected not to assert any of the remedies that would be available to him under ERISA, i.e., to clarify and

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[3] In Farlow v. Union Cent. Life Ins. Co., 874 F.2d 791 (11thCir.1989), the Eleventh Circuit Court of Appeals held that the Alabama twisting statute does not create a private cause of action.

enforce his rights under the terms of the plan as reprsented to him, and to obtain equitable relief (reformation of the health insurance contract to remove the time limitation on physical therapy and orthopedic appliances benefits), etc. 29 U.S.C. Section 1132(a). These benefits and an award of attorney fees could have been available to Menton under ERISA, whether he sued in federal or in state court, if he had prevailed on his ERISA claim. Pilot Life, 481 U.S. at 53, 107 S.Ct. at 1556. Therefore, ERISA did not deny Menton a remedy. At the conclusion of Pilot Life, 481 U.S. at 57, 107 S.Ct. at 1558, Justice O'Connor wrote:

> "Metropolitan Life [Ins. Co. v. Massachusetts, supra], did not involve a state law that conflicted with a substantive provision of ERISA. Therefore the Court's general observation -- that state laws related to ERISA may also fall under the

> saving clause --was not focused on any particular relationship or conflict between a substantive provision of ERISA and a state law. In particular, the Court had no occasion to consider in Metropolitan Life the question raised in the present case: whether Congress might clearly express, through the structure and legislative history of a particular substantive provision of ERISA, an intention that the federal remedy provided by that provision displace statue causes of action. ...
>
> "Considering the common-sense understanding of the saving clause, The McCarran-Ferguson Act factors defining the business of insurance, and, most importantly, the clear expression of congressional intent that ERISA's civil enforcement scheme be exclusive, we conclude that Dedeaux's state law suit asserting improper processing of a claim for benefits under an ERISA-regulated plan is not saved by Section 514(b)(2)(A), and therefore is pre-empted by Section 514(a)."

This action was filed while Hood v. Prudential Ins. Co. of America, supra (Hood I), was the law. Prior to final judgment in this case, the United States Supreme Court decided Pilot Life, supra, and we decided

Seafarers' Welfare Plan v. Dixon, supra. However, it was after final judgment in this case that this Court reversed Hood v. Prudential Ins. Co. of America, supra (Hood II) and decided Landy v. Travelers Insurance Co., supra. Therefore, I would reverse the judgment of the trial court; however, rather than rendering judgment or remanding with instructions that the trial court grant HealthAmerica and Merle's motion for JNOV, I would reverse and remand and afford Menton the opportunity to amend to state a claim under ERISA.

At the time this complaint was filed, Menton had every reason to believe, every reason to predict, that this state law cause of action asserting misrepresentation of coverage afforded by a health insurance plan would not be preempted by ERISA. See Hood I. During the course of this litigation in

the circuit court and during this appeal, the rules were changed. This Court could not and did not predict this. See Hood I.

I, as a member of the Supreme Court of Alabama, will not thwart an opportunity for a remedy for one whose right to a particular remedy was foreclosed only by his astute attorney's not being able to guess how Justices would rule. It seems appropriate and altogether just to invoke equitable relief, which is afforded by 29 U.S.C. Section 1132(a)(3), to one whose civil cause of action was foreclosed by an expansion of the ERISA preemption after that cause of action had accrued and after an action to enforce it had been filed. See Culberson v. Bankers Life Co., 541 So.2d 480 (Ala.1989).

I would reverse and remand to permit Menton to amend and proceed with a cause of

action under ERISA, 29 U.S.C. Section 1132(a). Therefore, I dissent.

Maddox, J., concurs.